New York City District Council of Carpenters

BENEFIT FUNDS

New York City District Council of Carpenters Welfare Fund

SUMMARY PLAN DESCRIPTION

Effective April 1, 2022

For:

- Active Participants Working in Outside Construction and Shop Employment
- Retired Participants Who Have Worked in Outside Construction and Shop Employment
- Active and Retired Employees of:
  - the District Council
  - Local Unions
  - NYCDCC Benefit Funds
  - Hollow Metal Funds
  - CCA Metro – Carpenter Contractor Alliance of Metropolitan New York

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For
Active Participants Working in Outside Construction and Shop Employment, Retired Participants Who Have Worked in Outside Construction and Shop Employment, and Active and Retired Employees of the District Council, Local Unions, NYCDCC Benefit Funds, the Hollow Metal Funds, and CCA Metro – Carpenter Contractor Alliance of Metropolitan New York

Effective April 1, 2022

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ABOUT THIS DOCUMENT

This document summarizes the benefits provided by the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund," the "Fund," or the "Plan") as of April 1, 2022. It serves as both the Plan document and the Summary Plan Description (the "SPD"). It supersedes all prior SPDs and all Summaries of Material Modifications ("SMMs") issued prior to April 1, 2022. It is intended to provide an easy-to-understand explanation of the benefits available through the Fund.

From time to time, there may be changes in the Fund's benefits and/or procedures. When that happens, you will be notified in writing of any change through an SMM. You should keep these SMMs with this SPD. SMMs will be sent to you at the address that appears in Fund Office records. For this reason, be sure to notify the Fund Office if your address changes. Please note that digital versions of this SPD and related SMMs can be found on the Benefit Funds' website at **www.nyccbf.org**. The Benefit Funds' website is an important source of information that provides forms, news, and various information about your benefits. We encourage you to use this resource as often as possible.

This SPD offers a comprehensive resource about the benefits provided by the Fund. It is organized to give you quick access to easy-to-understand explanations of your benefits. To make the best use of your benefits, review this SPD carefully and share it with your family.

This SPD uses everyday language to explain your benefits; however, there are certain technical terms that apply to the Fund. These terms are defined in the *Glossary* section at the end of the SPD and are in **bold** type the first time they appear. Words that are capitalized in this SPD – such as "Active Employee" and "Covered Employment" – are generally defined in the *Glossary* at the end of the SPD. In some cases, they are also defined in the text.

This SPD and the Benefit Funds staff are your sources of information on the Plan. If you have any questions about the Plan and how its coverage works, the Benefit Funds staff will be glad to help you. However, because telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this SPD. As such, we encourage you to submit any issues or questions you have regarding your benefits to the Fund Office in writing.

Ayuda en Español Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el New York City District Council of Carpenters Welfare Fund. Si usted tiene dificultad en entender cualquier parte de este folleto, puede communicarse con la oficinia del plan en 395 Hudson Street, New York, NY 10014. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., lunes a viernes. También puede llamar la oficina del plan al 800-529-3863 para ayuda.

OVERVIEW OF WELFARE FUND BENEFITS

The New York City District Council of Carpenters Welfare Fund provides a comprehensive package of benefits to Active Participants and their Eligible Dependents. Benefits include:

- Medical, **Hospital**, mental health services, prescription drug, dental, vision care, and hearing benefits;
- Disability benefits that help protect you if **Illness** or **Injury** prevents you from working;
- Paid Family Leave that provides you with replacement income if you take time off from work due to certain reasons, such as to care for a newly born, adopted or fostered child, or a sick family member;
- Life insurance and Accidental Death & Dismemberment benefits that help protect your family upon your injury or death;
- A scholarship program that can provide financial assistance for your Child's education; and
- A vacation benefits program (described in a separate SPD).

The Fund also provides a comprehensive package of benefits to eligible Retirees, eligible Disability Retirees, and their Eligible Dependents. Benefits include:

- Medical, **Hospital**, mental health services, prescription drug, dental, vision care, and hearing benefits;
- Life insurance benefits that help protect your family upon your death; and
- A scholarship program that can provide financial assistance for your Child's education.

For More Information

About your . . .	Contact . . .
General Eligibility Questions	**Fund Office** 800-529-3863 or 212-366-7373 **www.nyccbf.org**
Health Care Coverage • Medical/Hospital • Mental Health and Substance Abuse Treatment • Guided Cancer Care and Treatment	**Empire BlueCross BlueShield** 844-416-6387 (Empire) 212-366-7590 (MEND) **www.empireblue.com** *MSK Direct* 833-786-3368
Prescription Drug Coverage	**Express Scripts** Non-Medicare: 800-939-2091 Medicare: 800-311-2757 **www.express-scripts.com**
Vision Care Coverage and Hearing Exams & Hearing Aids Coverage	**Comprehensive Professional Systems, Inc. ("CPS")** 212-675-5745 **https://cpshearing.com** or **www.cpsoptical.com** **General Vision Services ("GVS")** 212-594-2580 **www.generalvision.com/hearing**
Dental Coverage	**Administrative Services Only Inc./ Self-Insured Dental Services ("ASO/SIDS")** 800-537-1238 **www.asonet.com**
Life Insurance Coverage	**Amalgamated Life Insurance Company** 914-367-5000
Scholarship and Recognition Program	**International Scholarship and Tuition Services ("ISTS")** 855-670-4787 **https://aim.applyists.net/NYCDCC**
Disability Coverage (Active Participants Only)	**Fund Office** 800-529-3863 or 212-366-7373 **www.nyccbf.org**
Paid Family Leave (Active Participants Only)	**Amalgamated Employee Benefits Administrators** 833-941-1057 **SubmitClaimForms@amalgamatedbenefits.com**
Vacation Benefits (Active Participants Only) *Vacation Benefits are described in a separate SPD.	**Fund Office** 800-529-3863 or 212-366-7373 **www.nyccbf.org**
Health Care Coverage for Medicare-Eligible Retirees and Dependents (Retired Participants Only)	**UnitedHealthcare** 888-736-7441 **www.uhcretiree.com**

ABOUT YOUR PARTICIPATION

This section describes the eligibility rules for medical, prescription drug, dental, life insurance, vision care, and hearing coverage that apply to eligible **Active Employees** and their covered dependents; and Retirees and their covered dependents. The different rules that apply to Short-Term Disability (for Active Employees only), Paid Family Leave (for Active Employees only) and Scholarship benefits are explained in the sections on those benefits.

Eligibility for Active Employees and Hours Bank

In general, you are eligible for Welfare Fund coverage as an Active Employee after you have worked 250 hours in **Covered Employment**. These 250 hours "buy" you a calendar quarter (three months) of coverage. If you work at least 250 hours in Covered Employment during one of the following periods, you will be covered for the calendar quarter beginning on the date shown below:

If you work 250 hours during:	Coverage Begins:
October, November, December	January 1
January, February, March	April 1
April, May, June	July 1
July, August, September	October 1

When you work more than 250 hours, the excess hours are saved in your "bank" for use in the immediate future. If you do not work enough hours to establish or maintain your coverage, these hours are also saved in the bank for use in the immediate future. Hours worked during a calendar quarter may be used for the calendar quarter immediately following the quarter in which they were worked and, if they remain unused, for three additional calendar quarters. You may not accumulate more than 750 hours in the bank at any time.

> **EXAMPLE: Assume you have no hours in your bank but then work 350 hours in April, May and June. 250 of those hours will be used to "buy" coverage for the calendar quarter beginning July 1.**
>
> **The 100 excess hours will remain in your bank and may be used toward coverage in the immediate future. If you work at least 150 additional hours between July and September of the same year, you will have enough hours in your bank to qualify for coverage in the quarter beginning October 1.**

If you have at least 200 but less than 250 bank hours, you can "buy" the missing hours and extend or establish your eligibility for a calendar quarter. The cost for the missing hours will be the current hourly Welfare Fund contribution rate for building construction contractors. Check with the Fund Office for the current rate before submitting payment. At the beginning of each calendar quarter, the Fund Office will notify you if you are eligible to buy the missing hours and extend or establish your eligibility for the calendar quarter.

EXAMPLE: If you have 230 bank hours, you can "buy" the remaining 20 hours and bring your total bank hours to 250, which is the minimum number of hours required for one calendar quarter of Welfare Fund coverage. Your self-pay contribution would be determined by multiplying 20 hours by the hourly Welfare Fund contribution rate for building construction contractors. Note: the rate changes periodically. You will be notified by the Fund Office when it changes, or you can call the Fund Office to find out the current contribution rate.

If you are working in Covered Employment and your hours have not yet been reported to the Fund Office, you have a "benefit shortage," not a "self-pay."

NOTE: In the event of a dispute regarding whether work you performed constituted Covered Employment, you bear the burden of proving that work performed was Covered Employment. Your employer's report of your earnings to the Social Security Administration is not by itself sufficient to prove that your work qualified as Covered Employment. Therefore, you should retain records, such as your pay stubs and daily records of your work in Covered Employment, in order to prove your eligibility for benefits. The Trustees have the right to determine whether evidence submitted by you is adequate to establish that you performed Covered Employment.

Benefit Shortages

It is very important for you to regularly check that all of your hours in Covered Employment are properly credited to you. To do this, we suggest that you keep a daily record of your work in Covered Employment in which you note the name of the employer, the number of hours you work, and the jobsite location. You should also retain your pay stubs until you verify that the hours have been properly credited to you. You can check the hours credited to you by:

- Logging onto the Benefit Funds website at **www.nyccbf.org** using your UBC number and PIN (contact the Fund Office to reset your PIN, if necessary);
- Calling the Fund Office IVR at 800-529-3863 or 212-366-7373, and following the prompts to "credited hours"; or
- Calling the Fund at 800-529-3863 or 212-366-7373 and speaking to a representative.

You are required to submit a Benefit Hours Shortage Report as soon as you become aware that your employer is either not reporting or not reporting correctly your hours in Covered Employment. Benefit Hours Shortage Report forms are available at **www.nyccbf.org/member/benefit-shortages/**.

You may mail copies of your pay stubs along with your completed Benefit Hours Shortage Report to:

New York City District Council of Carpenters Benefit Funds
395 Hudson Street
New York, NY 10014
Attention: Internal Delinquencies Department

Benefit Hours Shortage Reports and pay stubs may also be faxed or emailed. You may fax your Benefit Hours Shortage Reports and pay stubs to 212-366-7357 or you may email them to **shortages@nyccbf.org**. Keep a copy of your completed Benefit Hours Shortage Report and pay stubs for your records.

You are responsible for regularly checking your hours and, when appropriate, for submitting timely Benefit Hours Shortage Reports. Once the Fund Office verifies that a Benefit Hours Shortage Report is valid, hours will be credited to you for the payroll periods when you actually worked those hours. Therefore, if your Benefit Hours Shortage Report is not filed timely, the hours credited to you may fall outside the current eligibility period and may only establish retroactive eligibility for past calendar quarters.

The charts below illustrate why it's important to check your hours regularly and to file Benefit Hours Shortage Reports in a timely fashion.

Benefit Shortages – Example One: When No Benefit Shortage is Filed

Calendar Quarter	Start Bank	Eligible Y/N	Bank Hours Forward	Hours Worked in Quarter	Hours Reported by Employer	Valid Shortages Filed	Next Calendar Quarter's Bank
First (January – March)	100	N	100	200	0	0	100
Second (April – June)	100	N	100	75	75	0	175
Third (July – September)	175	N	175	0	0	0	175

At the start of the calendar quarter beginning on January 1, you have 100 bank hours. Since you have less than 250 bank hours, you are not eligible for coverage during the January – March quarter. Although you work 200 hours in Covered Employment during the January – March quarter, your employer never reports the hours to the Fund. Because you don't check your hours regularly, you are unaware that the 200 hours have not been credited to you. You still have only 100 hours at the start of the calendar quarter beginning on April 1 and therefore you remain ineligible for coverage for the April – June quarter.

You work 75 hours in Covered Employment during the middle of June, and your employer timely reports these 75 hours to the Fund. Toward the end of June, you schedule a medical appointment for mid-July believing that your 75 hours in June, when added to your 200 hours in the first quarter, establishes your eligibility for coverage during the calendar quarter beginning on July 1.

In July, prior to your appointment, the medical office informs you that, according to Empire BlueCross BlueShield ("Empire"), you do not have coverage with the Fund. At that point (in July), you call the Fund Office and first learn that the 200 hours you worked during January – March were never reported to the Fund.

You file a Benefit Shortage Report in July for the 200 hours worked from January – March and the Fund Office determines that the report is valid. The 200 hours are credited to the January – March quarter (the payroll periods when the hours were actually worked). The chart below illustrates your eligibility status for the same three quarters after the Shortage Report was submitted and determined to be valid.

Benefit Shortages – Example Two: When a Benefit Shortage is Filed

Quarter	Start Bank	Eligible Y/N	Bank Hours Forward	Hours Worked in Quarter	Hours Reported by Employer	Valid Shortages Filed	Next Quarter's Bank
First (January – March)	100	N	100	200	0	200	300
Second (April – June)	300	Y	50	75	75	0	125
Third (July – September)	125	N	125	0	0	0	125

Although you wanted to establish eligibility for the July – September quarter (based on your medical appointment scheduled for July), the 200 hours when credited established eligibility for the April – June quarter. You remain ineligible for the July – September quarter.

Remember: Check your hours regularly to ensure that all your hours in Covered Employment are properly credited to you, and, if the hours have not been credited to you, be sure to file timely Benefit Shortage Reports.

Benefit shortage hours only provide credit for Welfare eligibility—they **do not** provide credit for your Vacation benefit. In order to receive Vacation benefits, your employer must pay the required contributions.

Forfeiture of Hours in the Bank

Your bank hours will be forfeited if:

- Hours in the bank have not been used for a consecutive twelve-month period following the calendar quarter in which they were worked. (The Fund maintains separate "buckets" for hours by calendar quarter in which hours are worked to ensure that they are forfeited on a rolling basis.);

- You have knowledge and do not notify the Fund Office that hours you have worked have not been reported or have been only partially reported;
- You fail to notify the Fund or its administrators of any additional group health coverage for your dependents that would otherwise have primary liability for their claims; and/or
- You perform work covered under the New York City District Council of Carpenters' trade jurisdiction for an employer who is not required to contribute to the Fund on your behalf.

Continued Eligibility During Periods of Disability

If you receive short-term disability or Workers' Compensation benefits under applicable state law while you are an eligible Active Employee, you will be credited with up to 20 hours for each week you receive those benefits, up to a total of 26 weeks, or 520 hours, in a rolling 52-week period that begins on the date you became disabled. This credit is not applied more than once during a period of disability. To receive this credit, you must submit proof to the Fund Office that you are in receipt of these benefits, and you must be enrolled as an eligible Active Employee on the date you become disabled.

Continued Eligibility During Paid Family Leave

If you receive Paid Family Leave benefits under applicable New York law, you will automatically be credited with up to 4 hours daily while receiving those benefits, up to a total of 12 weeks annually.

Eligibility for Retirees

When you retire, any remaining hours in your bank are used to continue your coverage as an Active Employee. In order for coverage to continue after your bank hours are used, you must qualify for Retiree or Disability Retiree coverage and you must pay all of the required monthly Retiree Premiums as described later in this section.

In order to be eligible for Welfare Fund coverage as a Retiree, your employer(s) must have contributed to the Fund for you as an Active Employee, you must be at least 55 years old, and you must satisfy one of the following three requirements:

- You have earned at least 30 Vesting Credits from the New York City District Council of Carpenters Pension Fund (the "Pension Fund") as of the effective date of your pension; or
- You have earned at least 20 Vesting Credits from the Pension Fund and were covered by the Welfare Fund as an Active Employee for any 24 months during the 60-month period immediately preceding the effective date of your benefit payments from the Pension Fund; or
- You have earned at least 15 Vesting Credits from the Pension Fund, have 25 years with at least 250 hours worked in Covered Employment each year, and were covered by the Welfare Fund as an Active Employee for any 24 months during the 60-month period immediately preceding the effective date of your benefit payments from the Pension Fund.

While Vesting Credit attributable to City of New York employment and Pro Rata or Reciprocal Vesting Credit earned from the pension funds of other Carpenters jurisdictions may help you avoid losing credit under the Pension Fund due to a break in service under the Pension Fund's rules, such credit is not used to satisfy any of the above three requirements for Retiree Welfare Fund eligibility.

Vesting Credit earned under the "Continuous Non-Covered Employment" provision of the Pension Fund does not count toward your Retiree eligibility in the Welfare Fund. As a general rule, Vesting Credit earned in the Pension Fund counts toward Retiree eligibility in the Welfare Fund only when your employer is making contributions to the Welfare Fund on your behalf for work performed as an Active Employee.

Return to Work

If you return to Covered Employment after you retire, but do not work more than 39.5 hours per month, you will not "bank" hours and therefore you will not re-qualify for coverage as an Active Employee even if work 250 hours or more in Covered Employment.

If you return to Covered Employment for 40 hours or more per month and your pension is suspended, your Welfare Fund coverage as a Retiree will automatically continue for up to three months. Your Welfare Fund coverage may continue for an additional six months, provided that you continue to work 40 hours in Covered Employment in each preceding month. During this period, you will begin accumulating bank hours toward future Active Employee eligibility and any newly accrued hours and Vesting Credits will be used to determine your eligibility for Retiree coverage at the time of your new pension effective date. Your Retiree Welfare coverage may be subject to the Medicare as Secondary Payer Rule, if applicable.

For example, suppose you have 19 Vesting Credits as of your original Regular Pension effective date of July 1, 2015 and that you do not satisfy the eligibility requirements for Retiree Welfare coverage at that time. You returned to Covered Employment for more than 39.5 hours per month on January 1, 2017 and, as a result, the Pension Fund suspended your pension. You work for the next 18 months and elect to commence your pension once again on July 1, 2018. At the time of your new pension effective date, you have 20.5 Vesting Credits which is enough credit for you to now be eligible for Retiree Welfare coverage.

Suppose you stop working in Covered Employment and commence your pension benefit and then subsequently return to Covered Employment for no more than 39.5 hours per month prior to age 70, which means that your pension benefits are not suspended. Suppose that when you reach age 70, you increase your amount of Covered Employment since the Pension Fund permits you to work an unlimited number of hours in Covered Employment without having your pension suspended after you reach age 70. In this example, you will still not "bank" hours either before or after you reach age 70 and you will continue to have Retiree Welfare coverage.

However, if you do not retire but rather remain in Covered Employment past age 70, you will be covered as an Active Employee under the Welfare Fund both before and after age 70 even if you elect to commence your pension benefit at age 70. If, at some point, you stop working (or stop working sufficient hours to maintain your Welfare Fund coverage as an Active Employee), your Retiree Welfare coverage will commence, assuming you meet the requirements for such coverage.

Disqualifying Employment Rules

Disqualifying Employment under the Welfare Fund means any work in the states of New York and New Jersey that falls under the trade jurisdiction of the New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America (the "District Council") for an employer who is not required to contribute to the Welfare Fund on your behalf. As explained below, Disqualifying

Employment performed either while you have Retiree Welfare coverage or before you have Retiree Welfare coverage will impact your eligibility for Retiree Welfare coverage.

No Minimum Number of Hours Allowed in
Disqualifying Employment under the Welfare Fund

There is no minimum number of hours that you may work in Disqualifying Employment without it impacting your Welfare Fund coverage. If you work *even one hour* in Disqualifying Employment, you are subject to these rules.

Disqualifying Employment *After* Commencement of Retiree Welfare Coverage

The first month that you work in Disqualifying Employment.
If you work in Disqualifying Employment one time, regardless of the number of hours you work, you will be responsible for reimbursing the Welfare Fund for the cost of any benefits provided to you and your dependents during that period.

If you work in Disqualifying Employment in a second month – regardless of whether the second month immediately follows the first month in which you worked in Disqualifying Employment or occurs at any time thereafter and regardless of the number of hours you work per month – you will *permanently* lose your eligibility for Retiree Welfare coverage in addition to being responsible for reimbursing the Welfare Fund for the cost of any benefits provided to you and your family during your period of Disqualifying Employment. For example, if you work one day in Disqualifying Employment in July, and two days in Disqualifying Employment in September, you will permanently forfeit your eligibility for Retiree Welfare coverage in September because you worked in Disqualifying Employment in two months even though the two months were not consecutive and even though you only worked three days in those two months. This same rule would apply if your second month of Disqualifying Employment occurred in a different year than your first month of Disqualifying Employment.

Notice Requirements

In order for the Welfare Fund to review the effect of any potential employment on your coverage, you must advise the Welfare Fund in writing of the employment prior to commencing the employment. You may obtain a Reemployment Questionnaire by contacting the Fund Office. From time to time, we may ask you to provide information about your employment. We may request Social Security Administration or Internal Revenue Service records to verify the accuracy of the information you give us. Failure to provide the requested information will result in your Welfare eligibility being suspended pending your provision of such information. Compliance with your notice obligations is necessary to ensure that your coverage is timely terminated and that you do not become liable to the Welfare Fund for the cost of any benefits provided to you if you work in Disqualifying Employment. However, compliance with the notice obligations will not preclude termination of your coverage if you work in Disqualifying Employment.

Eligibility for Retiree Coverage After a Permanent Forfeiture

If you permanently forfeit your eligibility for Retiree Welfare coverage, in order to become eligible again for Retiree Welfare coverage, you must return to Covered Employment and subsequently satisfy the

eligibility requirements for Retiree Welfare coverage based solely on your work in Covered Employment following your Disqualifying Employment.

Disqualifying Employment *Before* Commencement of Retiree Welfare Coverage

If you work in Disqualifying Employment in two (2) or more months on or after July 1, 2019 in the fifteen (15) years before you would otherwise be eligible for Retiree Welfare coverage, you will be permanently ineligible for Retiree Welfare coverage. It does not matter whether the months are consecutive or not, and it does not matter how many hours you work in a month. You will be required to provide information about your employment at the time you apply for Retiree Welfare coverage, including, but not limited to, Social Security Administration or Internal Revenue Service records. Failure to provide the requested information will result in denial of your application for Retiree Welfare coverage. If you want to know whether certain employment will impact your eligibility for Retiree Welfare coverage in the future, you must advise the Welfare Fund in writing of the employment prior to commencing the employment and request a written determination from the Fund Office regarding the effect of such employment on your eligibility for Retiree Welfare coverage in the future.

Appeal Procedures

If you wish to appeal the Welfare Fund's determination that you engaged in Disqualifying Employment, you must submit a written appeal to the Fund Office within 180 days from the date of the notice you receive from the Welfare Fund advising of its determination that certain employment constitutes Disqualifying Employment or that you are ineligible for Retiree Welfare coverage because you worked in Disqualifying Employment.

Your appeal should state your reasons for the appeal and include supporting documentation and a completed authorization for us to obtain information about your employment from your Employer. An authorization form can be obtained by contacting the Fund Office.

Your appeal will be decided at the next meeting of the Appeals Committee of the Board of Trustees, unless your appeal is received by the Fund Office less than 30 days prior to the next regularly scheduled meeting in which case your appeal will be heard at the second regularly scheduled meeting of the Appeals Committee following receipt of such appeal.

Disability Pensioners

You may be eligible for Retiree health coverage as a Disability Pensioner if you satisfy certain conditions. This benefit does not provide a cash benefit.

The eligibility requirements differ based on whether you are in Phase I –the initial 24 months of your disability – or Phase II – the 25th month of your disability and beyond.

If you become Totally Disabled and eligible for Disability Retiree coverage while you are an eligible Active Employee, your Disability Retiree coverage will remain in effect for as long as you remain disabled, pay the premium, and satisfy all other applicable requirements.

You are considered Totally Disabled during Phase I - the first 24 months of disability* - if you meet all of the following requirements:

1. You must have been an eligible Active Employee under the Welfare Fund when your disability commenced,
2. You are unable to work in Covered Employment due to an Illness or Injury,
3. You have accrued at least five (5) Vesting Credits in the Pension Fund immediately prior to the date of your disability, and
4. You have been awarded a Phase I Disability Pension from the Pension Fund.

*If your Phase I Disability Pension from the Pension Fund is extended beyond the first 24 months of disability pending resolution of your Social Security Disability Award application in accordance with the rules of the Pension Fund, your Retiree health coverage as a Disability Pensioner will also be extended during the period of your Disability Pension extension.

In addition, if, based on the eligibility requirements below, you would qualify for continuation of Welfare Fund coverage after your first 24 months of continuation of Welfare Fund coverage, you may be eligible for an extension of your Welfare Fund coverage for a period of up to nine months. Specifically, if your Social Security claim is on appeal and the Pension Fund extends your Disability Pension for a period of up to six months based upon a determination by the Pension Fund's physician that you are Totally Disabled in accordance with the rules of the Pension Fund, your Welfare Fund coverage will likewise be extended for the same period of time that your Disability Pension benefits from the Pension Fund are extended, plus an additional 3-month extension.

In order to be eligible for Retiree health coverage during your Phase II period (after 24 months of disability), you are Totally Disabled if you meet all of the following requirements:

1. You are unable to work in any occupation due to an Illness or Injury, as evidenced by receipt of a Social Security Disability Award,
2. You have at least 20 Vesting Credits in the Pension Fund as of the date of your disability, and
3. You have been awarded a Phase II Disability Pension from the Pension Fund.

If you are determined to be Totally Disabled, the Fund Office may request proof of continued disability from time to time.

If you become Totally Disabled, your remaining bank hours are used to continue your coverage as an Active Employee. Once your bank hours are used, your coverage will change from Active to Retiree coverage and you will be required to pay a monthly premium for your coverage.

If your Disability Pension is suspended because you recover or you no longer qualify or because you transition from a Phase I to Phase II Disability Pension but do not have enough vesting credits to continue Welfare Fund coverage, your Retiree coverage will automatically continue for up to three months. If you return to Covered Employment within that period, it will continue for up to six consecutive months after the first three months, provided you work at least 40 hours in Covered Employment in each preceding month. During this six-month period, you will begin accumulating hours in your bank toward future eligibility. Your Retiree coverage during this period may be subject to the Medicare as Secondary Payer Rule, if applicable.

Monthly Premiums

When you retire, your remaining bank hours are used to continue your coverage as an Active Employee. In order for Welfare Fund coverage to continue after your bank hours are exhausted, you must qualify

for Retiree or Disability Retiree Welfare coverage and you must pay the required monthly premium in full.

You must enroll in an electronic payment option for payment of monthly premiums. You may elect to have your premium deducted from (a) your monthly pension check or (b) your checking account through automated clearing house ("ACH") debit. By providing your banking information to the Fund, you are authorizing the Fund to continue deducting premium payments from such bank account for your surviving dependents (if applicable) to prevent a lapse of their coverage upon your death before your dependents provide updated account information.

In general, ACH premium payments will be debited from your bank account on or about the 15th day of the month prior to the month of coverage. If the 15th day falls on a holiday or a weekend, this deduction will take place on the business day immediately before or after this date. The Fund will make one attempt to deduct your premium by ACH. If your bank rejects or returns your premium, you must submit updated/correct checking account information to the Fund immediately to avoid termination. Should the bank reject or return another premium, your Retiree Welfare coverage will be terminated, and you will have to wait until the next open enrollment to resume your coverage.

If the premium rates for Retiree Welfare coverage is changed, the Fund will automatically deduct the new premium amount from your monthly pension check or bank account. No additional action is required for you to authorize deduction of the new amount. However, the Fund will always notify you in advance of premium changes for Retiree Welfare coverage.

Option 1: Automatic Deduction from your Monthly Pension Benefit. If you are currently receiving a monthly pension benefit from the Pension Fund or the Retirement and Pension Plan for Officers and Employees of the New York City District Council of Carpenters and Related Organizations (the "Officers Fund"), you may authorize the Pension Fund or Officers Fund to automatically deduct your Retiree Welfare Fund premium from your pension check by completing a Retiree Medical Premium Election Form. You must provide all requested information, check the Pension Deduction box, sign and date the form, and return it to the Fund.

Option 2: Automatic Withdrawal from your Bank Account. If you do not receive a Pension Fund or Officers Fund benefit, or if you choose not to authorize a deduction from your monthly pension, then you must authorize the Welfare Fund to automatically debit your Retiree premium from your bank account. The Welfare Fund can only debit your checking account from a bank, credit union, or savings association; the deduction may not be made from a money market, line of credit, or an investment account. The premium will be debited from your bank account on or about the 15th day of the month prior to the month of coverage. If the 15th day falls on a holiday or a weekend, the deduction will take place on the business day either before or after the holiday or weekend.

To authorize automatic withdrawals from your bank account, you must complete a Retiree Medical Premium Election Form along with an Automatic Withdrawal Authorization Form, provide all requested information, check the Automatic Bank Withdrawal Authorization box, provide the name(s) of the account holder, the routing number, and the bank account number, sign and date the form, and return it to the Fund. You must include a voided check from your account with your completed form.

*The banking information provided may be used in the future to continue premium payments for surviving dependents, when applicable, to prevent a lapse of their coverage upon your death.

The monthly premiums are subject to change at any time. The premiums in effect as of 2022 are as follows:

	Non-Medicare	Combination	Both Medicare
Retiree Only	$37.50 per month	N/A	$14.00 per month
Retiree + 1	$77.50 per month	$53.25 per month	$29.00 per month
Retiree + Family	$117.00 per month	$92.75 per month	$44.00 per month

Dependent Coverage

Coverage for your eligible dependents starts when your coverage starts, provided you complete and submit the required enrollment documents. Please see the Retiree Eligibility section for additional information on enrollment and submission of required documentation. Unless you are Medicare-Eligible Retiree, coverage for your enrolled dependents is the same medical, hospital, prescription drug, vision care, dental and hearing coverage that you receive. Please see the Medicare-Eligible section on page 119 for additional information.

To ensure coverage for your dependents starts at the same time as your coverage, you must provide the Fund Office with a Dependent Enrollment Form and supporting documents, as shown in the following chart.

Relationship	Description	Documentation*
Spouse	• Your current lawful spouse • An ex-spouse is not an eligible dependent	• Marriage certificate; **and** • Copy of your spouse's Social Security Card or Individual Taxpayer Identification Number (ITIN); **and** • Birth certificate (if spouse's date of birth is not stated on marriage certificate).
Child up to Age 26	• Biological Child	• Birth certificate; **and** • Copy of your dependent's Social Security Card.
	• Adopted Child ○ a Child placed in your home by a licensed placement agency in connection with adoption; or ○ a foster Child for whom foster care payments are made and a petition for adoption has been filed	• Copy of your dependent's Social Security Card; **and** • Birth certificate showing adoptive parents; or • Certificate of adoption; or • Adoption Agency acknowledgement of intent to adopt.
	• Stepchild ○ Your dependent stepchild who is in a regular parent-Child relationship, provided that no court order or agreement specifies that primary support or medical coverage for the stepchild is the obligation of an individual other than your spouse	• Marriage certificate between you and parent of Child; **and** • Birth certificate of the stepchild; **and** • Copy of your dependent's Social Security Card.
	• Qualified Medical Child Support Order ○ Any Child for whom you are required to cover due to a court order	• Copy of your dependent's Social Security Card; **and** • Court order signed by a judge; or • Medical support order issued by a state agency.
Child for Whom You are the Court-Appointed Legal Custodian or Guardian	• Any Child for whom you are the court-appointed legal custodian or guardian and for whom you are required to provide support	• Copy of your dependent's Social Security Card; **and** • Court order signed by a judge.

Relationship	Description	Documentation*
Disabled Child	A Child of any age who satisfies all the following conditions: • The Child depends on you for more than one-half of his/her financial support; • The Child lives with you in the same principal residence for more than half the calendar year except for temporary absences due to special circumstances, such as education, Illness or if the Child resides in a treatment center; • The Child was incapacitated before reaching the limiting age and while covered under the Fund; • If your Child is age 26 or older, he/she must have a Social Security Disability Award, which must be effective prior to age 26 to be eligible for continued Fund coverage; and • You provide the required proof of incapacity to the Fund Office within 12 months of the date the Child's coverage would have otherwise ended. The Trustees reserve the right to have such eligible dependent examined by a doctor of their choice to determine the existence of such incapacity.	• Copy of your dependent's Social Security Card; **and** • Birth Certificate; **and** • Marriage certificate between you and Child's parent if stepchild; **and** • Social Security Disability award; **and** • Request for Over-Age Dependent Coverage.
Dependent Parents	Provided you are not married nor have any dependent Children A dependent parent who is eligible for tax-free health coverage as a "qualifying relative" under the requirements of Internal Revenue Code Section 152(d) who can be and is lawfully claimed as a dependent on the employee's federal income tax return for each plan year for which coverage is provided.	• Copy of your (the employee's) birth certificate or copy of adoption papers; **and** • Copy of tax return for each Plan Year for which coverage is provided; **and** • Copy of parent's Social Security card; **and** • Copy of parent's birth certificate; **and** • Copy of parent's Medicare Card (if applicable).

*__Note for Participants Who Are Submitting Foreign Documents as Proof of Eligibility__

If your dependent documentation was issued in a foreign country and is not in English, you must provide a copy of the document translated into English for it to be acceptable proof of dependent status. Any document provided as proof of eligibility that is in a foreign language (such as a marriage certificate or a birth certificate) **must** be completely translated into English and **must** be certified with a letter of accuracy from the translator.

If you acquire dependents after your coverage begins, they will become covered on the date they become eligible dependents as long as you timely notify the Fund Office as described in the section of this SPD entitled *Changes in Status* below.

The Fund Office may investigate the status of any Dependent at any time. The Fund Office may require at any time copies of court orders, property settlement agreements, divorce orders, birth certificates, paternity determinations, guardianship orders, adoption papers, tax returns, Social Security award/denial letters, or any other document or information related to the determination of an individual's status as a Dependent. A failure to provide the requested documentation may result in the termination of coverage for you and your dependents.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order ("QMCSO") is an order issued by a state court or agency that requires an individual to provide coverage under a group health plan to a Child. Upon receipt of such an order, the Fund will review the order's status in accordance with the Fund's QMCSO procedures. For more information on QMCSOs, please contact the Fund Office.

Changes in Status and Special Enrollment

It is of critical importance that you notify the Fund Office immediately by calling toll-free 800-529-3863 if you have either a change of address or one of the following changes in status:

- Marriage, separation, Legal Separation, or divorce;
- Birth, adoption or placement of a Child for adoption;
- You are not working and you are receiving Workers' Compensation benefits or disability benefits;
- A dependent Child ceases to be eligible for dependent coverage;
- You or a dependent becomes entitled to Medicare;
- You take a leave of absence for military service;
- You take a leave of absence for family or medical purposes;
- A covered person dies;
- You or a dependent become covered under another health plan; or
- You or a dependent lose coverage under another health plan.

Adding a New Dependent

If you have coverage when a Child is born, your newborn will automatically be covered for medical under Empire BlueCross BlueShield for 30 days from the date of birth. To continue your Child's coverage beyond that time, you must enroll the Child by completing an enrollment form and submitting a copy of the Child's birth certificate and Social Security Card as soon as they are available. You can obtain a copy of the enrollment form by calling the Fund Office or visiting the Fund's website at **www.nyccbf.com**.

What Happens if You Get Divorced?

If you get divorced, your former spouse will remain covered under your Welfare Fund coverage until the last day of the month in which the judge signs your divorce judgment. It is extremely important that you notify the Welfare Fund of your divorce and provide a copy of your divorce judgment to the Welfare Fund as soon as possible because your former spouse's coverage will terminate at the end of the month in which the judge signed the divorce judgment. You and your former spouse will be responsible for reimbursing the Welfare Fund the cost of any benefits and premiums paid on behalf of your former spouse or former stepchildren after the last day of the month in which the judge signed the divorce judgment. In addition, in order for your former spouse or former stepchildren to be eligible for COBRA coverage, you or your former spouse must provide notice of your divorce within 60 days of the date of divorce. If the Welfare Fund does not receive notice of the divorce within 60 days of the divorce, your former spouse and stepchildren will lose the right to COBRA eligibility. As noted, a delay in timely notification will also make you liable for any health claims and premiums paid by the Welfare Fund after your spouse and stepchildren ceased to be eligible. Even if you think your former spouse has provided notice, we urge you to provide notice to eliminate any doubts since you will both be financially responsible for any claims paid in error and you and your current dependents risk losing health coverage if reimbursement is not made to the Welfare Fund. If you are a Retiree and your ex-spouse received Welfare Fund Retiree Coverage, the cost of your monthly premium will be reduced.

IMPORTANT: A divorce does not change your **Beneficiary** or invalidate your prior designation of your former spouse as Beneficiary for your life insurance or accidental death and dismemberment benefit. If you are divorced and wish to change your Beneficiary for these benefits, you must submit a new Beneficiary designation form to the Fund Office.

Dis-enrolling Covered Dependents

Spouse. A spouse who wants to utilize his/her own health coverage does not need to dis-enroll from this coverage as a spouse's employment-based coverage will always be primary, and the Welfare Fund's coverage will be the spouse's secondary coverage. In such instances, you must contact the appropriate Health Organization directly to update your "Coordination of Benefits" status as soon as possible. (See page 3.

Children. When a Child has group health coverage under the plans of both parents and the Fund's coverage would be primary for the Child (see the birthday rule, page 123), you have the option of dis-enrolling your Child from the Fund's coverage when the Fund's **Copayments** and coinsurance are considerably higher under this Fund than under your spouse's coverage. In order to do so, both parents must provide the Fund with separate notarized letters requesting dis-enrollment and proof of other coverage. The effective date of the dis-enrollment must be specified and both parents must clearly state that they understand the Child will not be covered for any Fund benefits on and after the effective date of the disenrollment, subject to any HIPAA "Special Enrollment" rights that your Child may have. If your Child is employed and has group health coverage based on your Child's employment, you must contact the appropriate Health Organization directly and update your Child's Coordination of Benefits status as soon as possible (see page 3). The plan that covers your Child as an employee will be primary and the Fund's coverage will be secondary.

PLEASE NOTE that the Fund will not honor dis-enrollment requests when a dependent is enrolled or is enrolling with Medicaid in the absence of documentation deemed to be sufficient by the Fund Office based on all of the circumstances.

Coverage Following Death

If you die while an eligible Active Employee or an eligible Retiree, your spouse and Children who are covered at the time of your death are eligible to continue coverage under the Welfare Fund for up to 60 months from the date of your death. Children must continue to satisfy the eligibility requirements above in order to maintain their coverage. A monthly premium is required for this coverage. The premiums in effect as of 2022 are $50 per month for an Active Employee, $25 per month for a Medicare-Eligible Retiree, and $70 per month for a Non-Medicare-Eligible Retiree. If one or more of your surviving children reside in a different household than your surviving spouse, the premium payment will be prorated based on the headcount of covered Children/spouse per household. For example, if you have 3 surviving Children and 1 surviving spouse who are split between two households, the unit with 3 covered dependents will pay 75% of the premium and the unit with 1 covered dependent will pay 25% of the premium. The Trustees may change the amount of the premium at any time in their sole discretion.

In order to be eligible for this extension of coverage, your Surviving Spouse and/or Children must enroll in an electronic payment option for payment of monthly premiums pursuant to which premiums are deducted from (a) a monthly pension check or (b) a checking account through ACH debit.

The coverage for your survivors runs concurrently with their eligibility to continue coverage under the federal law known as COBRA (described later in this section) and satisfies the Fund's obligation under COBRA.

Coverage During Certain Leaves of Absence (Applicable to Active Employees Only)

Family and Medical Leave Act

Under the Family and Medical Leave Act of 1993 ("FMLA"), you may be able to take up to 12 weeks of unpaid leave during any 12-month period:

- To care for a newly born or adopted Child;
- To care for a spouse, parent or Child who has a serious health problem;
- If you have a serious health problem that prevents you from performing your job; or
- If you have a qualifying need because your spouse, your Child or your parent is called to active military duty.

During your FMLA leave, you will maintain the coverage for which you were eligible at the time of your leave until the end of your leave, as long as your employer properly grants the leave under the FMLA and makes the required notifications and contributions to the Fund on your behalf.

The Fund has no role in granting FMLA leave. Your employer can grant FMLA leave, and your Fund coverage will continue for as long as your employer continues making the required contributions to maintain your eligibility. If your employer stops making contributions on your behalf, or if you exhaust your FMLA leave, COBRA Continuation Coverage may be available. (See page 24 for more information about COBRA.)

In addition, pursuant to amendments to the FMLA by the National Defense Authorization Act of 2008, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member if that individual is your spouse, Child, parent or next of kin, is undergoing treatment or therapy for an Illness or Injury that occurred in the line of military duty, and is an outpatient or on the armed services' temporary retired list.

If you do not return to work after your FMLA leave ends, you may be required to repay your employer the contributions it made to the Fund on your behalf during your FMLA leave. However, if your failure to return to work is due to the serious health condition of you or a family member or other circumstances beyond your control, the repayment requirement may not apply.

Contact your employer for more information regarding your rights under FMLA.

New York Paid Family Leave Law

The New York Paid Family Leave ("PFL") law requires job-protected, paid time off from work for private employees:

- to care for a seriously ill family member;
- to bond with a newborn, adopted, or foster child; or
- for military exigency (as defined by the FMLA).

Full-time employees, which are defined by PFL as employees with a regular schedule of 20 or more hours per week, will be eligible for coverage after 26 weeks of consecutive employment, while part-time employees will be eligible after 175 days of employment.

The Welfare Fund provides PFL benefits to **Active** participants of the Fund who meet the above eligibility criteria, subject to the following exceptions:

1. If an employer contributes to the Fund pursuant to a collective bargaining agreement ("CBA") on behalf of an employee who has elected to have contributions reciprocated to another welfare fund pursuant to a reciprocal agreement, such employee is not a participant in the Fund and shall not be eligible for PFL coverage from this Fund notwithstanding that contributions have been made on his/her behalf (since the contributions are or will be reciprocated to another welfare fund).
2. If an employer contributes to the Fund on behalf of a non-bargaining unit employee under a participation agreement and such employee is not covered by the Fund for short-term disability, such employee shall not be eligible for PFL from the Fund.
3. Participants employed by the City of New York shall not be eligible for PFL from the Fund.

You may obtain a claim form from the Fund's website at **www.nyccbf.org** or by contacting the **Fund Office (800) 529-FUND (3863**). You may also contact Amalgamated at (833) 941-1057 for questions about PFL.

Military Leave

If you leave employment to enter the uniformed services as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), your and your dependents' eligibility for coverage will end. However, if you satisfy the eligibility criteria under USERRA, you may be able to elect to continue health coverage under the Fund for yourself and your dependents. While you are on

USERRA leave, you have the choice to use your remaining bank hours to pay for your Continuation Coverage or to freeze your remaining bank hours until you return to Covered Employment.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, coverage under the Fund will continue. If your service continues for 31 days or more, you may elect to continue coverage under the Fund by making monthly self-payments. The amount of the self-payments will be the same as the COBRA Continuation Coverage self-payments. (See page 24 for more information about COBRA.) In addition, your dependents may be eligible for health care under the Civilian Health & Medical Program of the Uniformed Services ("TRICARE"). If you and/or your dependents are covered by both this Fund and TRICARE, this Fund pays first and TRICARE pays second. This Fund will coordinate coverage with TRICARE. See the ***Coordination of Benefits*** section on page 123 for more information.

If you are eligible and elect to continue coverage under USERRA, your coverage under the Fund may continue (at a maximum) until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your Fund coverage would otherwise end.

However, your coverage under USERRA may end before the end of the maximum period (described above). Your coverage will end at midnight on the earliest of the day:

- The Fund ceases to provide any health plan to any employee;
- Your self-payment contribution is due and not paid on a timely basis;
- Your uniformed service ends due to dishonorable discharge or other undesirable conduct; or
- You again become covered under the Fund.

Notice Requirements

You must notify the Fund Office in writing in advance of entering the uniformed services. If you fail to provide advance notice of your uniformed service, you may not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees decide to excuse your failure to provide advance notice, you may elect to continue coverage and pay all amounts required to continue coverage in accordance with the COBRA election and payment procedures as described starting on page 24. Your Continuation Coverage will only apply to periods for which the required contribution is paid.

Election, payment and termination of USERRA Continuation Coverage will be governed by the election, payment and termination rules for COBRA Continuation Coverage, provided COBRA rules do not conflict with USERRA. COBRA and USERRA run concurrently which means that if you are simultaneously eligible for COBRA and USERRA, you will be provided with the more generous benefit under each law for periods in which you are eligible for both forms of Continuation Coverage. If you fail to follow the COBRA rules when electing and paying for USERRA coverage, you may lose the right to continue USERRA coverage. However, if circumstances make it otherwise impossible or unreasonable for you to timely elect and pay for USERRA coverage, the Trustees may, in their sole discretion, reinstate your right to USERRA Continuation Coverage, provided you pay all amounts required for such Continuation Coverage.

For more information about continuing your coverage under USERRA, contact the Fund Office.

If You Do Not Continue Coverage Under USERRA

If you do not elect to continue coverage under USERRA, your coverage will end at the end of the calendar quarter in which you enter the armed forces. If your dependents are covered under the Fund at the time you enter the armed services, your eligible dependents may continue their coverage by electing and paying for COBRA Continuation Coverage.

Reinstating Your Coverage

Upon your honorable discharge from uniformed service, you may apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered by your former employer. Reemployment and reinstatement deadlines are based on your length of military service, as follows:

- Less than 31 days—you have one day after discharge (allowing 8 hours for travel) to return to work for a contributing employer;
- More than 30 days but less than 181 days—you have up to 14 days after discharge to return to work for a contributing employer; or
- More than 180 days—you have up to 90 days after discharge to return to work for a contributing employer.

When you are discharged, if you are hospitalized or recovering from an Illness or Injury that was incurred during your uniformed service, you have until the end of the period that is necessary for you to recover to return to Covered Employment. If your hours bank is frozen and you don't return to Covered Employment within the time frames indicated, you have the right to appeal your loss of bank hours.

When Coverage Ends

Your eligibility will end the earliest of the following:

- You no longer meet the Fund's eligibility requirements;
- The Fund ceases to provide coverage or an insurance company terminates the contract that provides your benefits;
- You or your covered dependents make a false statement on an enrollment form or claim form or otherwise engage in fraud as detailed on page 167 in the ***Fraud*** section; or;
- You or your covered dependent receive a benefit to which you were not entitled and you fail to reimburse the Fund.

Your dependents' coverage will end the earliest of:

- On the date your coverage ends; or
- On the last day of the month in which they no longer qualify as eligible dependents under the Fund.

Coverage for Retirees and their dependents will end on the earliest of the above reasons or upon a failure to pay the required premiums.

Coverage for you and/or your dependents may be terminated retroactively (rescinded) due to any of the following:

- In cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30 days' notice); or
- Due to non-payment of premiums (including COBRA and Retiree premiums).
- Failure to notify the Fund of a change in status. (e.g., divorce, Medicare eligibility, etc.).

A "rescission of coverage" refers to a retroactive cancellation or discontinuance of coverage, except to the extent that the rescission is due to a failure to pay timely premiums for coverage or fraud. You will be personally responsible for any claims that you incurred during the dates of coverage that are eliminated under the retroactive rescission. You may appeal a rescission of coverage even if the rescission does not have an adverse effect on any particular benefit. To appeal a rescission of coverage, follow the Claims and Appeals Procedures starting on page 139. In addition, rescissions of coverage are eligible for External Review. The External Review process can also be found in the Claims and Appeals Procedures section starting on page 139.

Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you and any covered dependents may be eligible to continue your coverage under certain circumstances when your coverage would otherwise end. You must make self-payments in order for coverage to continue. COBRA coverage includes medical, hospital, prescription drug, vision, dental, and hearing benefits that are identical to the coverage you had under the Fund while an Active Employee or Retiree. COBRA coverage is not available for Life Insurance or Accidental Death and Dismemberment ("AD&D") Insurance Benefits. The Fund Office administers COBRA coverage.

NOTE: If you are eligible for Retiree Welfare coverage from the Fund upon your retirement, you will have the option of electing COBRA continuation of your Active coverage (for a temporary period of time on a fully self-paid basis) or Retiree Welfare coverage (on the terms described on page 119). (Unlike Retiree Welfare coverage, you must pay the entire cost of COBRA Continuation Coverage.) If you do not timely elect COBRA Continuation Coverage when you retire, you will no longer have any COBRA rights, even if you later lose your Retiree Welfare coverage. However, if your spouse and/or dependent child(ren) who receive Retiree Welfare coverage lose that coverage due to a COBRA Qualifying Event (for example, if you die or get divorced), they will be entitled to continue the Retiree Welfare coverage on a self-pay basis in accordance with COBRA for up to 36 months from the date of the loss of Retiree Welfare coverage.

Other Health Coverage Alternatives to COBRA

Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at **www.Healthcare.gov**.

Enrolling in Marketplace Coverage

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make an enrollment decision. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or CHIP. You can access the Marketplace for your state at **www.HealthCare.gov.** Coverage through the Marketplace may cost less than COBRA coverage. Being offered COBRA Continuation Coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about Qualifying Events and special enrollment periods, visit **www.HealthCare.gov**.

You should keep in mind that if you sign up for COBRA Continuation Coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA Continuation Coverage early and switch to a Marketplace plan if you have another Qualifying Event such as marriage or birth of a child through something called a "special enrollment period." Be careful though - if you terminate your COBRA Continuation Coverage early without another Qualifying Event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and you could end up without any health coverage in the interim.

Once you have exhausted your COBRA Continuation Coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA Continuation Coverage, you cannot switch to COBRA Continuation Coverage once your election period ends.

Enrolling in another group health plan

You may be eligible to enroll in coverage under another group health plan (like your spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA Continuation Coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA Continuation Coverage.

Enrolling in Medicare instead of COBRA Continuation Coverage after coverage ends

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA Continuation Coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA Continuation Coverage and later enroll in Medicare Part A or B before the COBRA Continuation Coverage ends, the Plan may terminate your Continuation Coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA Continuation Coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs which results in the end of that person's health care coverage, 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.

"Qualified Beneficiary": Under the law, a Qualified Beneficiary is any Participant 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 child of the covered employee who is covered under the Plan during the employee's period of employment pursuant to a Qualified Medical Child Support Order ("QMCSO") is entitled to the same COBRA rights as an eligible Dependent Child. 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 COBRA Events

The following chart shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue. 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 which does not result in the loss of coverage under this Plan (e.g., employee continues working after becoming entitled to Medicare), then COBRA is not available.

The Fund has the authority to determine whether a Qualifying Event has occurred with respect to termination of employment and/or reduction in hours of employment.

If You Lose Coverage Because:	These People Would Be Eligible:	For COBRA Coverage Up to:
You have insufficient bank hours due to your employment terminating*	You and your covered Dependents	18 months **
You have insufficient bank hours due to your working hours being reduced	You and your covered Dependents	18 months **
You are on active military leave and you do not elect to continue coverage under USERRA (see page 21)	You and your covered Dependents	18 months **
You die	Your covered Dependents	36 months ***
You divorce	Your covered former Spouse and Stepchildren	36 months
Your Child no longer qualifies for coverage	Your covered Child	36 months

* For any reason other than gross misconduct.

** Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of Continuation Coverage, become Totally Disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11-month period is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage.

*** If you die, your covered dependents may be eligible to continue coverage at the Fund's partial expense for up to 60 months, subject to payment of a monthly premium. The 36 months of COBRA continuation are included in the coverage the Fund provides to your dependents after you die.

Newly Acquired Dependents

If you acquire a new dependent while your COBRA Continuation Coverage is in effect, you may add that dependent to your coverage by notifying the Fund Office of the change within 30 days. Adding dependents to your coverage may affect your premium amount.

FMLA Leave

If you are on an FMLA leave of absence, you will not experience a Qualifying Event. However, if you do not return to active employment after your FMLA leave of absence, you will experience a Qualifying Event due to the termination of your employment. This Qualifying Event will occur at the earlier of the end of the FMLA leave or the date that you notify your employer that you will not be returning to active employment.

Multiple Qualifying Events While Covered Under COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another Qualifying Event while you are already covered under COBRA. If you are covered under COBRA for 18 months because of your termination of employment or reduction in hours, your dependents who were covered at the time of the first Qualifying Event (spouse, Child or other eligible dependent) may extend coverage for another 18 months in the event of your death or if:

- You get divorced;
- Your Child is no longer eligible as your dependent under the Fund's definition; or

- You become eligible for Medicare.

As an example, let's say you stop working, lose coverage, and you and your covered dependents enroll in COBRA Continuation Coverage for 18 months. Three months after your COBRA Continuation Coverage begins, however, your Child turns age 26 and no longer qualifies for coverage under the Fund. Your Child then can continue COBRA Continuation Coverage separately for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage. Notice to the Fund Office within 60 days of this second Qualifying Event and timely election to continue coverage and self-payment are required to extend coverage.

You, as the eligible employee, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment terminates or you have a reduction in hours (unless you become disabled during the first 60 days of COBRA Continuation Coverage). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and you may not extend your coverage.

Notifying the Fund Office

Both you and the Fund Office have responsibilities when Qualifying Events occur that make you or your covered dependents eligible for COBRA Continuation Coverage. You must notify the Fund Office when your employment with the City of New York ends. Your family must notify the Fund Office upon your death. You or your dependent must notify the Fund Office in writing within 60 days of a divorce or a Child's loss of dependent status under the Fund. If you do not notify the Fund Office within 60 days of such an event, you and/or your covered dependents will lose the right to elect COBRA Continuation Coverage.

When the Fund Office is timely notified of a Qualifying Event, you and your covered dependents will be notified of your right to elect COBRA Continuation Coverage, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. For more information, visit **www.Healthcare.gov.**

You have 60 days from the later of (1) the date that coverage would be lost or (2) the date that the notice is provided in which to elect COBRA Continuation Coverage. Your covered dependents may elect coverage independently from you if you choose not to elect COBRA Continuation Coverage. For example, your spouse may elect COBRA Continuation Coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or all Children who are qualified Beneficiaries. A parent may elect to continue coverage on behalf of any Children. You or your spouse can elect COBRA Continuation Coverage on behalf of all Qualified Beneficiaries.

In determining whether to elect COBRA Continuation Coverage, you should consider the consequences if you fail to continue your group health coverage. You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event. You will also have the same special enrollment rights at the end of COBRA Continuation Coverage if you elect and maintain COBRA Continuation Coverage for the maximum time available to you.

If you or a dependent provides notice to the Fund Office of:

- A divorce;

- Ineligibility of a dependent for coverage under the Fund; or
- A second Qualifying Event;

and if you and/or the dependent are not entitled to COBRA Continuation Coverage, the Fund Office will send you a written notice indicating why you are not eligible for such coverage.

Paying for COBRA Continuation Coverage

If you or a covered dependent chooses to continue coverage under COBRA, you or your covered dependent must pay the full cost of the coverage plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, your cost will increase to 150% of the full cost of continued coverage between the 19th and the 29th months of coverage.

Your first payment must be made within 45 days after you elect to continue coverage and must include payments for any months retroactive to the day that you and/or your covered dependents' coverage under the Fund ended.

Subsequent payments are due the first of the month and must be made no later than 30 days from that date. A payment is considered made on the date on which it is sent to the Fund. If there is a question as to the date sent, the Fund Office will use the postmark date as the date sent.

The 30-day period is your grace period. If you pay after the due date but before your grace period expires, the Fund Office will terminate your coverage effective as of the due date and then reinstate your coverage retroactive to that date. If a payment is late (after the grace period expires), your late payment will be returned and your coverage will remain terminated as of the last day of the month for which timely payment was made.

The Fund has a special policy concerning your dependents' coverage after you die. Under this policy, your dependents do not have to pay for COBRA Continuation Coverage. The Fund will provide coverage for 60 months after your death, provided your dependents pay a monthly premium, which is less than the costs of COBRA Continuation Coverage. See ***Coverage Following Death*** on page 20 for more information. Please note that the first 36 months of this extension will run concurrently with COBRA and satisfy the Fund's COBRA obligation. Coverage will terminate after the first 36-months if the Surviving Spouse remarries. In no event will coverage last more than 60 months.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage for you and/or your covered dependents may end for any of the following reasons:

- Coverage has continued for the maximum 18-, 29- or 36-month period;
- The Fund no longer provides group health coverage;
- The Fund terminates coverage for cause, such as fraudulent claim submission, on the same basis that coverage could terminate in a similar situation for Active Employees;
- You or a dependent do not pay the cost of your COBRA Continuation Coverage when it is due or within any grace period;
- A Qualified Beneficiary becomes eligible for other group health plan after the election;
- You are continuing coverage during the 19th to 29th months of a disability and the Social Security Administration determines that you are no longer disabled; or
- You or a covered dependent becomes entitled to Medicare after the COBRA election.

COBRA Claims

Claims incurred by you will not be paid unless you have elected COBRA Continuation Coverage and paid the premiums.

Summary

This description of your COBRA rights is only a general summary of the law. The law itself must be consulted to determine how the law would apply in any particular circumstance. Failing to pay your COBRA premium on time may lead to a rescission of coverage, as explained on page 24. You will be personally responsible for any claims that you incurred during the dates of coverage that are retroactively rescinded.

HOSPITAL AND MEDICAL BENEFITS

The Medical Plan

The Fund provides three levels of coverage, as follows:

- The **Active** level provides coverage to eligible Active Employees and their dependents. An Active Employee is a participant who is currently eligible using bank hours. When you retire, your remaining bank hours are used to continue your coverage as an Active Employee.
- The **Pre-Medicare Retiree** level provides the same level of coverage as the Active level (except for deductibles and co-insurance and the requirement to pay premiums) to eligible Retirees and their dependents who are under age 65 or not otherwise eligible for Medicare. A Retiree is any eligible participant who meets the eligibility requirements on page 8 and who is not currently eligible for Active Employee coverage using bank hours, including participants eligible under the *Disability Pensioners* section on page 11. Surviving dependents are also covered under the Retiree level of benefits.
- The **Medicare Supplemental Retiree** level provides coverage to eligible Retirees who are age 65 and over, their dependents who are age 65 and over, and a Retiree or dependent of a Retiree who is eligible for Medicare or who becomes eligible for Medicare prior to age 65. Under this coverage, covered benefits are subject to Medicare **Deductibles**, Coinsurance, premiums, and determination of covered expenses. See the section entitled "Medical Benefits for Medicare-Eligible Retirees and Dependents" for details about this benefit.

  If you are eligible for Medicare, or become eligible for Medicare, and your current Fund eligibility is not based upon your or a family member's bank hours, Medicare has the primary responsibility for your claims; the Welfare Fund has secondary responsibility through the UnitedHealthcare Group Medicare Advantage ("PPO") Plan (the "UHC Plan"). **However, you must enroll in both Medicare Part A and Medicare Part B and make timely payment of the required premiums in order to be eligible for coverage under the UHC Plan.** If you are eligible for Medicare, but do not enroll in both Medicare Part A and Part B, you will not be permitted to enroll in the UHC Plan and, instead you will only be eligible for prescription drug coverage with Express Scripts and ancillary benefits such as Vision, Dental, and Hearing. The Fund does not provide any secondary responsibility for Medicare Part A or Part B claims without your proper enrollment in the UHC Plan.

Limitations on Benefits

The following sections describe the Hospital and Medical Benefits available under the Fund. Starting on page 139 the *Claims and Appeals Procedures; Grievances and Appeals for Claims Administered by Empire; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Appeals for Dental Benefits, Complaints & Appeals; Other Information You Should Know; and Your Rights Under the Employee Retirement Income Security Act of 1974* sections describe the actions you can take to appeal a denial of benefits. If you or your Beneficiary take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How Active and Pre-Medicare Retiree Level of Coverage Works

The Fund's Hospital and medical coverage for Active Employees and Pre-Medicare retirees is offered through Empire's Point of Service network ("POS") or Empire's Preferred Provider Organization ("PPO") network. The network you are enrolled in is determined based on your residence. If you reside in Empire's **Operating Area** or its contiguous counties, you will be enrolled in the POS program. If you reside outside of Empire's Operating Area, you will be enrolled in the PPO program. Both the POS and PPO Programs have identical In-Network and Out-of-Network cost-sharing provisions.

Empire's POS Operating Area			
New York		New Jersey	Connecticut
Albany	Schenectady	Bergen	Fairfield
Clinton	Schoharie	Hudson	Litchfield
Columbia	Suffolk	Middlesex	
Delaware	Sullivan	Monmouth	
Duchess	Warren	Passaic	
Essex	Washington	Sussex	
Fulton	Westchester	Union	
Greene			
Montgomery	**New York City**		
Nassau	Bronx		
Orange	Kings		
Putnam	Queens		
Rensselaer	New York		
Rockland	Richmond		
Saratoga			

- If you live in one of the counties listed above, select a **Provider** from the Empire POS Network.
- If you live in another county, select a Provider from the PPO Network of the local BlueCross BlueShield affiliate.

How benefits are paid depends on where you receive care, as described below:

Active Level of Coverage

- **If you receive services from a Hospital**.
  - Hospitals in Empire's network or a local BlueCross BlueShield ("BCBS") network send bills directly to Empire or the local network. The Fund will pay 90% of the Allowed Amount for services after you satisfy the In-Network Deductible.
  - **Non-Participating Hospitals** may provide you with the bill to submit to Empire. The Fund will pay 70% of the **Allowed Amount** for the services after you satisfy the **Out-of-Network Deductible**. You will be responsible for 30% of the Allowed Amount as well as any fee in excess of the Allowed Amount.
  - All claims must be submitted to the Local Empire BCBS Plan in order to expedite processing and ensure that all information is provided to Empire.

- **If you see a Provider for an office visit.**
    - Providers that participate in Empire's network or a local BCBS network will collect the appropriate Copayment from you at the time of the office visit and submit the claim directly to Empire or the local network.
    - If you have an office visit with a Non-Participating Provider, the Provider may ask you to pay up front. You or the Provider must file a claim with Empire or the local BCBS network. Once the claim is received and processed, Empire will send you an Explanation of Benefits ("EOB"), which explains how the claim was adjudicated. The Fund will pay 70% of the Allowed Amount for the services after you satisfy the Deductible. You will be responsible for 30% of the Allowed Amount plus any fee in excess of the Allowed Amount.
- **If you see a Provider for services.**
    - Providers that participate in Empire's network or a local BCBS network will submit bills directly to Empire or the local network. The Fund will pay 90% of the Allowed Amount after you satisfy the In-Network Deductible.
    - If you visit a Non-Participating Provider, the Provider may ask you to pay up front. You or the Provider must file a claim with Empire or the local BCBS network. Once the claim is received and processed, Empire will send you an EOB, which explains how the claim was adjudicated. The Fund will pay 70% of the Allowed Amount for the services after you satisfy the Out-of-Network Deductible. You will be responsible for the Deductible and 30% of the Allowed Amount plus any fee in excess of the Allowed Amount.

Pre-Medicare Retiree Level of Coverage

- **If you receive services from a Hospital**.
    - Hospitals in Empire's network or a local BCBS network bill Empire or the local network directly. The Fund will pay 90% of the Maximum Allowed Amount for services after you satisfy the In-Network Deductible.
    - **Non-Participating Hospitals** may provide you with the bill to submit to Empire. The Fund will pay 60% of the Allowed Amount for the services after you satisfy the Out-of-Network Deductible. You will be responsible for 40% of the Allowed Amount plus any fee in excess of the Allowed Amount. All claims must be submitted to the Local Empire BCBS Plan.
- **If you see a Provider for an office visit.**
    - Providers that participate in Empire's network or a local BCBS network will collect the Copayment from you at the time of the office visit and submit the claim directly to Empire or the local network.
    - If you see a Non-Participating Provider for an office visit, the Provider may ask you to pay up front. You or the Provider must file a claim with Empire or the local BCBS network. Once the claim is received and processed, Empire will send you an EOB, which explains how the claim was adjudicated. The Fund will pay 60% of the Allowed Amount for the services after you satisfy the Deductible. You will be responsible for 40% of the Allowed Amount plus any fee in excess of the Allowed Amount.
- **If you see a Provider for services.**
    - Providers that participate in Empire's network or a local BCBS network will submit bills directly to Empire or the local network. The Fund will pay 90% of the Maximum Allowed Amount after you satisfy the In-Network Deductible.

- If you visit a Non-Participating Provider, the Provider may ask you to pay up front. You or the Provider must file a claim with Empire or the local BCBS network. Once the claim is received and processed, Empire will send you an EOB, which explains how the claim was adjudicated. The Fund will pay 60% of the Allowed Amount for the services after you satisfy the Out-of-Network Deductible. You will be responsible for the Deductible and 40% of the Allowed Amount plus any fee in excess of the Allowed Amount.

You will receive an EOB whenever a claim is processed.

Precertification

Precertification is required for certain services including admission to a Hospital and other Facilities, such as skilled nursing Facilities, maternity care, certain diagnostic tests and procedures and certain types of equipment and supplies. If you fail to pre-certify when required, your benefits may be reduced or denied entirely.

Empire's Medical Management Program handles precertification. You can reach Empire's Medical Management at 844-416-6387. Empire has set time frames for calling its Medical Management Program for precertification depending on the type of Hospital admission or procedure, as explained below.

- A planned Hospital admission or surgery should be pre-certified at least two weeks ahead of time;
- An emergency admission must be certified no later than 48 hours after the Hospital admission.

Maternity Care

- As soon as reasonably possible, with notification provided within the first three months of pregnancy when possible;
- Within 48 hours after the actual delivery date if the stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: 48 hours for a vaginal birth; or 96 hours for cesarean birth.

If you deliver your baby in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver your baby outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the 48-hour (or 96-hour) period, the Fund does not have to continue covering the stay for the one ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to the mother or the newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider.

Additional information concerning precertification and Empire's Medical Management Program is provided on pages 83-84.

In-Network Benefits and Procedures

This section summarizes your **In-Network Benefits** and Empire's procedures. You can reach Empire by phone at 844-416-6387 or by visiting **www.empireblue.com**. To register on Empire's website, follow these easy steps:

- Go to **www.empireblue.com**;
- Click "Register" on the left-hand side of the home page; and
- Follow the steps provided (Note that you'll need your Empire Member ID to register. Your Member ID number can be found on the front of your Empire Member ID Card).

Once you're registered on Empire's website, you can:

- Search for participating doctors and specialists;
- Check the status of claims;
- Receive information through your personal "Message Center;" and
- Get health information and tools with My Health, powered by WebMD.

Finding a Network Provider

You can locate a Network Provider by calling Empire at 844-416-6387 or visiting Empire's website at **www.empireblue.com**. Select the Point of Service network from the drop-down menu. The Fund Office can also help you locate a Network Provider.

When traveling in the United States, you can call 800-810-BLUE (800-810-2583) or visit **www.bcbs.com** for more information on Participating Providers.

When traveling outside the United States, contact the BlueCard Worldwide program at 804-673-1177 to obtain the names of **Participating Hospitals** and other Providers.

Inter-Plan Program

1. **Out-of-Area Services.** Empire has a variety of relationships with other BCBS Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the BCBS Association ("Association"). Whenever you access healthcare services outside of the geographic area Empire serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

   When you receive care outside of the Empire Service Area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local BCBS Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") do not contract with the Host Blue. We explain below how both kinds of Providers are paid.

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

2. **BlueCard® Program.** Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Empire will still fulfill its contractual obligations, but the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

   When you receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to the Plan.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. In some cases, it is an estimated price that takes into account special arrangements with that Provider. In other cases, the arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Empire used for your claim because they will not be applied after a claim has already been paid.

3. **Special Cases: Value-Based Programs.** BlueCard® Program. If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments.

4. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, Empire will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

5. **Non-Participating Providers Outside Our Service Area.**

   a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Service Area by non-participating providers, Empire may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment, or Coinsurance will be based on that Allowed Amount. You may also be responsible for the difference between the amount that the non-participating provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

   b. **Exceptions.** In certain situations, Empire may use other pricing methods, such as billed charges, the pricing the Fund would use if the healthcare services had been obtained within

the Empire Service Area, or a special negotiated price to determine the amount payable for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment made by the Fund for the Covered Services as set forth in this paragraph.

6. **BCBS Global Core® Program.** If you plan to travel outside the United States, call Empire's Member Services to find out your BCBS Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to have an up-to-date health ID card with you when you travel.

   When you are traveling abroad and need medical care, you can call the BCBS Global Core Service Center 24 hours a day, 7 days a week at 800-810-2583 (toll free) or collect at 804-673-1177.

   How claims are paid with BCBS Global Core. In most cases, when you arrange inpatient hospital care with BCBS Global Core, claims will be filed for you. The only amounts that you may need to pay up front are Copayment, Coinsurance, or Deductible amounts. You will typically need to pay for the following services up front:

   - Doctor's services;
   - Inpatient hospital care not arranged through BCBS Global Core; and
   - Outpatient services.

You must file a claim form for reimbursement for any payments made up front.

To obtain international claim forms:

- Call the BCBS Global Core Service Center at the numbers above; or
- Visit **www.bcbsglobalcore.com**.

You will find the address for mailing the claim on the form.

Transitional Care

Networks grow and change, and sometimes a Provider will leave the network. If you are an existing participant and the Provider with whom you are in an ongoing course of treatment leaves the network, Empire will notify you at least 30 calendar days prior to the Provider's termination or within 15 days after Empire becomes aware of the Provider's change in status.

You may continue to receive **Medically Necessary Covered Services** from a Provider for an ongoing course of treatment for up to 90 days after he/she leaves the network, if the Provider agrees to (1) accept reimbursement at the rates applicable prior to the start of transitional care, (2) adhere to Empire's quality assurance requirements, (3) provide Empire with necessary medical information related to this care, and (4) adhere to Empire's policies and procedures. After 90 days, you must select a new Provider. Transitional care will not be approved if the Provider leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the Provider's ability to practice.

New participants who are in treatment for a disabling and degenerative or life-threatening condition or disease are eligible for up to 60 days of continued care following their initial enrollment date.

Individuals who are pregnant and in their second or third trimester on the effective date of coverage may continue care through delivery and the postpartum period. The Provider must agree to (1) accept reimbursement at the rates applicable prior to start of transitional care, (2) adhere to Empire's quality assurance requirements, (3) provide Empire with necessary medical information related to this care, and (4) adhere to Empire's policies and procedures, in both situations. You must contact Empire's Medical Management department to arrange this continued care.

The Advantages of Specialty Care Coordinators and Specialty Care Centers

If you have a life-threatening or degenerative and disabling condition or disease, you may request a Specialty Care Coordinator ("SCC") to act as your Primary Care Physician ("PCP"). An SCC is a network specialist with expertise in treating disabling and degenerative or life-threatening conditions. The SCC can refer you to a Specialty Care Center, and will coordinate your care while you are receiving specialized services. When you have an office visit with an SCC, you pay the primary care visit Copayment (not the specialist visit Copayment).

To request an SCC, you must call Empire's Medical Management Program. Empire and your doctor, together with Empire's medical director and your specialist, must approve all SCC requests. Your care by the SCC will be given according to a treatment plan reviewed by Empire in consultation with you, your Physician, and the SCC. The advantage of having an SCC is that you can rely on the physician most responsible for your care, should a serious situation arise.

Examples of Specialty Care Centers include centers for the treatment of:

- HIV/AIDS (designated by the New York State AIDS Institute);
- Cerebral palsy (accredited by the New York State Department of Health);
- Cystic fibrosis (designated by the Cystic Fibrosis Foundation);
- Cancer (accredited by the National® Cancer Institute);
- Organ transplants (accredited by Medicare);
- Hemophilia (designated by the National Hemophilia Foundation);
- Multiple sclerosis (designated by the National Multiple Sclerosis Society); and
- Sickle cell disease (accredited by the National Institutes of Health).

Out-of-Network Benefits and Procedures

Out-of-Network services are health care services provided by a licensed Provider that does not participate in the Empire POS network or a PPO network of another BCBS affiliate. For most services, you may choose In-Network or **Out-of-Network Providers**. (However, some services are only covered In-Network; these are described later.) When you receive Out-of-Network care:

- You pay an annual "Deductible" and "Coinsurance" on each Covered Service, plus any amount above the "Allowed Amount" (see page 89);
- You will usually have to pay the Provider when you receive care; and
- You will need to file a claim form.

In general, benefits for Out-of-Network services are paid directly to you. Empire generally does not issue any payments directly to Out-of-Network Providers. It is your responsibility to pay the Out-of-Network Providers directly. If the Out-of-Network Provider charges more than the Fund pays or seeks to impose interest or attorney's fees or other fees for late payment or non-payment, you are solely responsible for such charges. That is why it is generally always less costly to you to use **In-Network Providers**.

The Deductible applies separately to each family member until the family Deductible is met. However, there is an exception to this policy called a "common accident benefit." If two or more family members are injured in the same accident and require medical care, only one individual Deductible must be met for all care related to the accident.

Examples of How Benefits are Calculated for In-Network and Out-of-Network Care: Active Level

	In-Network (Empire)	Out-of-Network
Specialist's Charge for Office Visit	$250	$250
Allowed Amount (see page 89 for an explanation of the Allowed Amount)	N/A	$200
Benefit Amount Paid	$100 (Allowed Amount)	$140 (70% of Allowed Amount)
Total Patient Responsibility	$25 Copayment	$110 (30% of Allowed Amount PLUS the difference between the Allowed Amount and the Specialist's Charge)
Note: This example assumes that individual Deductibles have already been satisfied.		

Examples of How Benefits are Calculated for In-Network and Out-of-Network Care: Pre-Medicare Level of Coverage

	In-Network (Empire)	Out-of-Network
Specialist's Charge for Office Visit	$250	$250
Allowed Amount (see page 89 for an explanation of the Allowed Amount)	N/A	$200
Benefit Amount Paid	$100 (Maximum Allowed Amount)	$120 (60% of Allowed Amount)
Total Patient Responsibility	$25 Copayment	$130 (40% of Allowed Amount PLUS the difference between the Allowed Amount and the Specialist's Charge)
Note: This example assumes that individual Deductibles have already been satisfied.		

Anti-Assignment Provision

The Fund categorically prohibits, and the Fund will not accept in any circumstances, any assignment or any attempt to assign any benefit claims or any other types of claims, regardless of the nature of such claims, to an Out-of-Network Provider or an Out-of-Network Hospital or Facility. This prohibition on assignments applies to any claims for benefits or monies alleged to be due under the Fund, any claim for a determination as to future rights to benefits under the Fund, any claim for access to documents or information under ERISA or any other applicable law, any claim for a breach or alleged breach of fiduciary duty under ERISA, and any and all other claims regardless of the nature of such claims. In the event that the Fund or a Health Organization makes a direct payment to an Out-of-Network Provider or an Out-of-Network Hospital or Facility or otherwise communicates to an Out-of-Network Provider or an Out-of-Network Hospital or Facility, such payment or communication shall in no way be construed or interpreted as a waiver of the Fund's prohibition on assignments.

Schedule of Benefits for Active Level of Coverage

The Fund provides a broad range of benefits to you and your family if you are eligible for the Active Level of Coverage. The following chart provides a brief overview of your coverage.

Some services require precertification with Empire's Medical Management Program. See the Medical Management section for details.

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
ANNUAL DEDUCTIBLE	$200/Individual $500/Family	$750/Individual $1,875/Family
COPAYMENT (Copayments are applied toward the Out-of-Pocket Maximum)		
• **Primary Care Office Visit**	$20 Copayment per visit	30% of Allowed Amount after Deductible is satisfied
• **Specialist Office Visit**	$25 Copayment per visit	30% of Allowed Amount after Deductible is satisfied
• **Emergency Room Visit**	$200 per visit (waived if admitted)	$200 per visit (waived if admitted)
COINSURANCE (Coinsurance payments are applied toward the Out-of-Pocket Maximum)	10% of Allowed Amount	30% of Allowed Amount
ANNUAL OUT-OF-POCKET MAXIMUM *(Including Annual Deductible, Copayment and Coinsurance)*	$1,900/Individual $4,750/Family	$3,750/Individual $9,375/Family
HOME, OFFICE/OUTPATIENT CARE		
HOME/OFFICE VISITS	$20 per primary care visit $25 per specialist visit	30% of Allowed Amount after Deductible is satisfied
SPECIALIST VISITS	$25 per visit	30% of Allowed Amount after Deductible is satisfied
CHIROPRACTIC CARE • Up to 45 visits per calendar year	$20 per visit	Not covered
ACUPUNCTURE • Unlimited visits	10% of Allowed Amount after Deductible is satisfied (a specialty copayment of $25 may apply if the provider bills for an office visit)	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
SECOND OR THIRD SURGICAL OPINION	$25 per visit	30% of Allowed Amount after Deductible is satisfied
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy (***precertification required)*** • MRIs/MRAs ***(precertification required)*** • Nuclear cardiology services ***(precertification required)*** • PET/CAT scans ***(precertification required)*** • Laboratory tests	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
DIABETES EDUCATION and MANAGEMENT	$20 per primary care visit $25 per specialist visit	30% of Allowed Amount after Deductible is satisfied
ALLERGY CARE • **Office Visit** • **Testing & Treatment**	$20 per primary care visit or $25 per specialist visit 10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied 30% of Allowed Amount after Deductible is satisfied
SURGERY • Pre-surgical testing • Anesthesia	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
CHEMOTHERAPY, RADIATION	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
KIDNEY DIALYSIS	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
CARDIAC REHABILITATION • Precertification required	$25 per visit	30% of Allowed Amount after Deductible is satisfied
PREVENTIVE CARE		
ANNUAL PHYSICAL EXAM • One per calendar year	$0	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**

DIAGNOSTIC SCREENING TESTS
• Cholesterol: 1 every 2 years (except for triglyceride testing)
• Diabetes (if pregnant or considering pregnancy)
• Colorectal cancer
  ○ Fecal occult blood test if age 40 or over: 1 per year
  ○ Sigmoidoscopy if age 40 or over: 1 every 2 years
• Routine Prostate Specific Antigen (PSA) in asymptomatic males
  ○ Over age 50: 1 every year
  ○ Between ages 40-49 if risk factors exist: 1 per year
  ○ If prior history of prostate cancer: PSA at any age
• Diagnostic PSA: 1 per year
	$0	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**

WELL-WOMAN CARE
• Office visits
• Pap smears
• Bone Density testing and treatment
  ○ Ages 52 through 65 - 1 baseline
  ○ Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
  ○ Under age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)*
• Mammogram (based on age and medical history)
  ○ Ages 35 through 39 – 1 baseline
  ○ Age 40 and older – 1 per year
• Women's sterilization procedures and counseling
• Breastfeeding support, supplies and counseling
  ○ One breast pump per year
  ○ Screenings and/or counseling for Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune deficiency (HIV), interpersonal and domestic violence
	$0	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**

WELL-CHILD CARE
• Covered Services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics
• In-Hospital visits
  ○ Newborn: 2 in-Hospital exams at birth following vaginal delivery or 4 in-Hospital exams at birth following C-section delivery
• Office visits
  ○ From birth through 11 years of age: 7 visits
  ○ Ages 12 through 17 years of age: 6 visits
  ○ Ages 18 to 21st birthday: 2 visits
• Lab tests ordered at the well-child visits and performed in the office or in the laboratory
• Certain immunizations (office visits are not required)
	$0	30% of Allowed Amount after Deductible is satisfied

EMERGENCY CARE		
EMERGENCY ROOM	$200 per visit (waived if admitted within 24 hours)	
PHYSICIAN'S OFFICE	$20 per primary care visit or $25 per specialist visit	30% of Allowed Amount after Deductible is satisfied
EMERGENCY AMBULANCE • Transportation by air or land ambulance to nearest acute care Hospital for emergency treatment	10% of Allowed Amount after Deductible is satisfied	
MATERNITY CARE and INFERTILITY TREATMENT		
PRENATAL and POSTNATAL CARE (In doctor's office) • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
LAB TESTS, SONOGRAMS and OTHER DIAGNOSTIC PROCEDURES	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
ROUTINE NEWBORN NURSERY CARE (In Hospital)	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
OBSTETRICAL CARE (In Hospital) • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
OBSTETRICAL CARE (In birthing center) • Precertification required	10% of Allowed Amount after Deductible is satisfied	Not covered
HOSPITAL SERVICES		
Please refer to the Health Management section for details regarding precertification requirements.		
SEMI-PRIVATE ROOM and BOARD • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
ANESTHESIA and OXYGEN	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
CHEMOTHERAPY and RADIATION THERAPY • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
DIAGNOSTIC X-RAYS and LAB TESTS	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
DRUGS and DRESSINGS	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
GENERAL, SPECIAL and CRITICAL NURSING CARE • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
INTENSIVE CARE • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
KIDNEY DIALYSIS • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
SERVICES of LICENSED PHYSICIANS and SURGEONS	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
SURGERY (Inpatient) • For a second procedure performed during an authorized surgery through the same incision, the Fund pays for the procedure with the higher Allowed Amount. • For a second procedure done through a separate incision, the Fund will pay the Allowed Amount for the procedure with the higher allowance and up to 50% of the Allowed Amount for the other procedure. • Precertification required	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
SURGERY (Outpatient) • For a second procedure performed during an authorized surgery through the same incision, the Fund pays for the procedure with the higher Allowed Amount. • For a second procedure done through a separate incision, the Fund will pay the Allowed Amount for the procedure with the higher allowance and up to 50% of the Allowed Amount for the other procedure. • Certain outpatient services require precertification. Before you schedule a procedure, ask your provider to contact Empire's Medical Management at 844-416-6387 to see if the procedure requires precertification. Failure to precertify may result in a penalty and/or denial of the claim if the service is not deemed to be medically necessary.	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	OUT-Of-NETWORK
DURABLE MEDICAL EQUIPMENT and SUPPLIES		
DURABLE MEDICAL EQUIPMENT (e.g., Hospital-type bed, wheelchair, sleep apnea monitor) • Precertification required	10% of Allowed Amount after Deductible is satisfied	Not covered
PROSTHETICS (e.g., artificial arms, legs, eyes, ears) • Precertification required	10% of Allowed Amount after Deductible is satisfied	Not covered
MEDICAL SUPPLIES (e.g., catheters, diabetic supplies, oxygen, syringes)	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
SKILLED NURSING and HOSPICE CARE (precertification required)		
SKILLED NURSING FACILITY • Up to 60 days per calendar year	10% of Allowed Amount after Deductible is satisfied	Not covered
HOME HEALTH CARE (precertification required)		
HOME HEALTH CARE • Up to 200 visits per calendar year (a visit equals 4 hours of care)	10% of Allowed Amount after Deductible is satisfied	Not covered
HOME INFUSION THERAPY	10% of Allowed Amount after Deductible is satisfied	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY (precertification required)		
PHYSICAL THERAPY, REHABILITATION, and HABILITATION • Up to 30 days of inpatient service per calendar year	10% of Allowed Amount after Deductible is satisfied	Not covered
• Up to 45 visits combined in home, office or outpatient Facility per calendar year	$20 per office visit $25 per Hospital setting visit	Not covered

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
OCCUPATIONAL, SPEECH, VISION THERAPY • Up to 45 visits per person combined in home, office or outpatient Facility per calendar year	$20 per office visit $25 per Hospital setting visit	Not covered
BEHAVIORAL/MENTAL HEALTH CARE		
Outpatient • Unlimited number of Medically Necessary visits	$20 per visit	30% of Allowed Amount after Deductible is satisfied
Non-Routine Outpatient (*precertification required) • Includes Intensive Outpatient ("IOP"), Partial Day Hospital ("PHP"), and Applied Behavioral Analysis	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
Inpatient (*precertification required) • Unlimited number of Medically Necessary days • Unlimited number of Medically Necessary visits from mental healthcare professionals	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
ALCOHOL OR SUBSTANCE ABUSE TREATMENT		
Outpatient • Unlimited number of Medically Necessary visits, including visits for family counseling	$20 per visit	30% of Allowed Amount after Deductible is satisfied
Non-Routine Outpatient (*precertification required) Includes IOP, PHP	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
Inpatient (*precertification required) • Unlimited number of Medically Necessary days of detoxification • Unlimited number of Medically Necessary rehabilitation days	10% of Allowed Amount after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

Schedule of Benefits for Pre-Medicare Retiree Level of Coverage

The Fund provides a broad range of benefits to you and your family if you are eligible for Pre-Medicare Retiree Level of Coverage. The following chart provides a brief overview of your coverage.

Some services require precertification with Empire's Medical Management Program. See the Medical Management section for details.

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
ANNUAL DEDUCTIBLE	$250/Individual $625/Family	$750/Individual $1,875/Family
COPAYMENT (Copayments are applied toward the Out-of-Pocket Maximum)		
• **Primary Care Office Visit**	$20 Copayment per visit	40% of Allowed Amount after Deductible is satisfied
• **Specialist Office Visit**	$25 Copayment per visit	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
• **Emergency Room Visit**	$200 per visit (waived if admitted)	$200 per visit (waived if admitted)
CO-INSURANCE	You pay 10% of Maximum Allowed Amount	40% of Allowed Amount
ANNUAL OUT-OF-POCKET MAXIMUM (Including Annual Deductible)	$2,000/Individual $5,000/Family	$3,750/Individual $9,375/Family
HOME, OFFICE/OUTPATIENT CARE		
HOME/OFFICE VISITS	$20 per primary care visit $25 per specialist visit	40% of Allowed Amount after Deductible is satisfied
SPECIALIST VISITS	$25 per visit	40% of Allowed Amount after Deductible is satisfied
CHIROPRACTIC CARE • Up to 45 visits per calendar year	$20 per visit	Not covered
ACUPUNCTURE • Unlimited visits	10% of Maximum Allowed Amount after Deductible is satisfied (a specialty copayment of $25 may apply if the provider bills for an office visit)	40% of Allowed Amount after Deductible is satisfied
SECOND OR THIRD SURGICAL OPINION	$25 per visit	40% of Allowed Amount after Deductible is satisfied
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy (***precertification required)*** • MRIs/MRAs ***(precertification required)*** • Nuclear cardiology services ***(precertification required)*** • PET/CAT scans ***(precertification required)*** • Laboratory tests	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
DIABETES EDUCATION and MANAGEMENT	$20 per primary care visit $25 per specialist visit	40% of Allowed Amount after Deductible is satisfied
ALLERGY CARE • **Office Visit** • **Testing & Treatment**	$20 per primary care visit or $25 per specialist visit 10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied 40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
SURGERY • Pre-surgical testing • Anesthesia	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
CHEMOTHERAPY, RADIATION	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
KIDNEY DIALYSIS	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
CARDIAC REHABILITATION	$25 per visit	40% of Allowed Amount after Deductible is satisfied
PREVENTIVE CARE		
ANNUAL PHYSICAL EXAM • One per calendar year	$0	40% of Allowed Amount after Deductible is satisfied

DIAGNOSTIC SCREENING TESTS
• Cholesterol: 1 every 2 years (except for triglyceride testing)
• Diabetes (if pregnant or considering pregnancy)
• Colorectal cancer
  ○ Fecal occult blood test if age 40 or over: 1 per year
  ○ Sigmoidoscopy if age 40 or over: 1 every 2 years
• Routine Prostate Specific Antigen ("PSA") in asymptomatic males
  ○ Over age 50: 1 every year
  ○ Between ages 40-49 if risk factors exist: 1 per year
  ○ If prior history of prostate cancer: PSA at any age
• Diagnostic PSA: 1 per year
	$0	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**

WELL-WOMAN CARE
• Office visits
• Pap smears
• Bone Density testing and treatment
  ○ Ages 52 through 65 - 1 baseline
  ○ Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
  ○ Under age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)*
• Mammogram (based on age and medical history)
  ○ Ages 35 through 39 – 1 baseline
  ○ Age 40 and older – 1 per year
• Women's sterilization procedures and counseling
• Breastfeeding support, supplies and counseling
  ○ One breast pump per year
  ○ Screenings and/or counseling for Gestational diabetes, Human Papillomavirus ("HPV"), sexually transmitted infections ("STIs"), Human immune deficiency ("HIV"), interpersonal and domestic violence
	$0	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**

WELL-CHILD CARE
• Covered Services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics
• In-Hospital visits
  ○ Newborn: 2 in-Hospital exams at birth following vaginal delivery or 4 in-Hospital exams at birth following C-section delivery
• Office visits
  ○ From birth through 11 years of age: 7 visits
  ○ Ages 12 through 17 years of age: 6 visits
  ○ Ages 18 to 21st birthday: 2 visits
• Lab tests ordered at the well-child visits and performed in the office or in the laboratory
• Certain immunizations (office visits are not required)
	$0	40% of Allowed Amount after Deductible is satisfied

EMERGENCY CARE		
EMERGENCY ROOM	$200 per visit (waived if admitted within 24 hours)	
PHYSICIAN'S OFFICE	$20 per primary care visit or $25 per specialist visit	40% of Allowed Amount after Deductible is satisfied
EMERGENCY AMBULANCE • Transportation by air or land ambulance to nearest acute care Hospital for emergency treatment	10% of Maximum Allowed Amount after Deductible is satisfied	
MATERNITY CARE and INFERTILITY TREATMENT		
PRENATAL and POSTNATAL CARE (In doctor's office) • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
LAB TESTS, SONOGRAMS and OTHER DIAGNOSTIC PROCEDURES	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
ROUTINE NEWBORN NURSERY CARE (In Hospital)	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
OBSTETRICAL CARE (In Hospital) • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
OBSTETRICAL CARE (In birthing center) • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
HOSPITAL SERVICES		
Please refer to the Health Management section for details regarding precertification requirements.		
SEMI-PRIVATE ROOM and BOARD • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
ANESTHESIA and OXYGEN	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
CHEMOTHERAPY and RADIATION THERAPY • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
DIAGNOSTIC X-RAYS and LAB TESTS	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
DRUGS and DRESSINGS	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
GENERAL, SPECIAL and CRITICAL NURSING CARE • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
INTENSIVE CARE • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
KIDNEY DIALYSIS • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
SERVICES OF LICENSED PHYSICIANS and SURGEONS	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
SURGERY (Inpatient) • For a second procedure performed during an authorized surgery through the same incision, the Fund pays for the procedure with the higher Maximum Allowed Amount. • For a second procedure done through a separate incision, the Fund will pay the Maximum Allowed Amount for the procedure with the higher allowance and up to 50% of the Maximum Allowed Amount for the other procedure. • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
SURGERY (Outpatient) • For a second procedure performed during an authorized surgery through the same incision, the Fund pays for the procedure with the higher Maximum Allowed Amount. • For a second procedure done through a separate incision, the Fund will pay the Maximum Allowed Amount for the procedure with the higher allowance and up to 50% of the Maximum Allowed Amount for the other procedure. • Certain outpatient services require precertification. Before you schedule a procedure, your provider should contact Empire's Medical Management at 844-416-6387 to determine if the procedure requires precertification. Failure to precertify may result in a penalty and/or denial of the claim if the service is not deemed to be medically necessary.	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
DURABLE MEDICAL EQUIPMENT and SUPPLIES		
DURABLE MEDICAL EQUIPMENT (e.g., Hospital-type bed, wheelchair, sleep apnea monitor) • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
PROSTHETICS (e.g., artificial arms, legs, eyes, ears) • Precertification required	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
MEDICAL SUPPLIES (e.g., catheters, diabetic supplies, oxygen, syringes)	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
SKILLED NURSING and HOSPICE CARE (precertification required)		
SKILLED NURSING FACILITY • Up to 60 days per calendar year	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
HOME HEALTH CARE (precertification required)		
HOME HEALTH CARE • Up to 200 visits per calendar year (a visit equals 4 hours of care)	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
HOME INFUSION THERAPY	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY (precertification required)		
PHYSICAL THERAPY, REHABILITATION, and HABILITATION • Up to 30 days of inpatient service per calendar year	10% of Maximum Allowed Amount after Deductible is satisfied	Not covered
• Up to 45 visits combined in home, office or outpatient Facility per calendar year	$20 per office visit $25 per Hospital setting visit	Not covered
OCCUPATIONAL, SPEECH, VISION THERAPY • Up to 45 visits per person combined in home, office or outpatient Facility per calendar year	$20 Co-pay for Professional Visit $25 Co-pay for Facility Visits	Not covered
BEHAVIORAL/MENTAL HEALTH CARE		
Outpatient • Unlimited number of Medically Necessary visits	$20 per visit	40% of Allowed Amount after Deductible is satisfied
Non-Routine Outpatient (*precertification required) • Includes Intensive Outpatient ("IOP"), Partial Day Hospital ("PHP"), and Applied Behavioral Analysis	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	**OUT-Of-NETWORK**
Inpatient (*precertification required) • Unlimited number of Medically Necessary days • Unlimited number of Medically Necessary visits from mental healthcare professionals	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
ALCOHOL OR SUBSTANCE ABUSE TREATMENT		
Outpatient • Unlimited number of Medically Necessary visits, including visits for family counseling	$20 per visit	40% of Allowed Amount after Deductible is satisfied
Non-Routine Outpatient (*precertification required) • Includes IOP, PHP, and Applied Behavioral Analysis	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied
Inpatient (*precertification required) • Unlimited number of Medically Necessary days of detoxification • Unlimited number of Medically Necessary rehabilitation days	10% of Maximum Allowed Amount after Deductible is satisfied	40% of Allowed Amount after Deductible is satisfied

What's Covered

Doctor's Services

The In-Network medical Copayment will apply to examination, evaluation and consultation services; In-Network Deductible and Coinsurance will apply to all other services received during the office visit, with the exception of Well-Child Care and Mental Health Care. There are no claim forms to fill out for X-rays, blood tests, or other diagnostic procedures provided that they are requested by the doctor and performed in the doctor's office or a Network **Facility**.

For In-Network allergy office visits, you pay only a Copayment. For In-Network allergy testing and treatments, you pay the Deductible and Coinsurance.

When you visit an Out-of-Network physician or use an Out-of-Network Facility for diagnostic procedures, including allergy testing and treatment visits, you pay the Deductible and Coinsurance, plus any amount above Empire's Allowed Amount.

What's Covered

Covered Services are listed in the ***Schedule of Benefits*** starting on page 41. The following are additional Covered Services and limitations:

- Consultation requested by the attending physician for advice on an Illness or Injury;
- Diabetes supplies prescribed by an authorized Provider:
    - Blood glucose monitors, including monitors for the legally blind,
    - Testing strips,
    - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and accessories, and insulin infusion devices,
    - Oral agents for controlling blood sugar,
    - Other equipment and supplies as required by law, and
    - Data management systems;
- Diabetes self-management education and diet information, including:
    - Education by a physician, certified nurse practitioner or member of their staff:
        - At the time of diagnosis,
        - When the patient's condition changes significantly, and
        - When Medically Necessary;
    - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate; and
    - Home visits for education when Medically Necessary;
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint ("TMJ") syndrome that is not a dental condition;

- Diagnosis and treatment for Orthognathic surgery (which can include surgeries to correct conditions of the jaw and face related to structure, growth, sleep apnea, TMJ disorders, malocclusion problems owing to skeletal disharmonies, or other orthodontic problems that cannot be easily treated with braces, that is not a dental condition;
- Medically Necessary hearing examinations;
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician; and
- Chiropractic care.

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

What's Not Covered

The following medical services are not covered:

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet, and chronic foot strain;
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes;
- Orthotics for treatment of routine foot care;
- Routine vision care (while this is excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide Vision Care Benefits; see page 115 for information about the Vision Care Benefits);
- Routine hearing exams (while this is excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide coverage for hearing exams and hearing aids; see page 117 for more information about the Fund's hearing benefits);
- Hearing aids and the examination for their fitting (while this is excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide coverage for hearing exams and hearing aids; see page 117 for more information about the Fund's hearing benefits);
- Services such as laboratory, X-ray and imaging, and pharmacy services as required by law from a Facility in which the referring physician or his/her immediate family member has a financial interest or relationship; and
- Services given by an unlicensed Provider or performed outside the scope of the Provider's license.

Preventive Services

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Individuals who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal law. Many Preventive Care Services are covered by the Fund with no Deductible, Copayments, or Coinsurance when provided by a Network Provider. These services fall under four broad categories as shown below:

A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"). Examples of these services are screenings for:
   - Breast cancer; Cervical cancer; Colorectal cancer
   - High blood pressure
   - Type 2 diabetes mellitus Cholesterol
   - Child and adult obesity

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations, including the following well-child care immunizations:
   - DPT (diphtheria, pertussis and tetanus)
   - Polio
   - MMR (measles, mumps and rubella)
   - Varicella (chicken pox)
   - Hepatitis B Hemophilus
   - Tetanus-diphtheria
   - Pneumococcal
   - Meningococcal Tetramune
   - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives

C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") including:
   - Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics ("AAP") and will be determined by your child's age.

   - Bone Mineral Density Measurements or Testing. The Fund covers bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the "Prescription Drug Coverage" section of this SPD. Bone mineral density measurements or tests, drugs or devices shall include those covered under Medicare and those in accordance with the criteria of the National Institutes of Health ("NIH"). You will qualify for coverage if you meet the criteria under Medicare or the criteria of the NIH or if you meet any of the following:
     - Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
     - With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
     - On a prescribed drug regimen posing a significant risk of osteoporosis;
     - With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
     - With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

The Fund also covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles, or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating

from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

D. Women's Preventive: Additional preventive care and screenings for women provided for in the guidelines supported by the HRSA, including the following:

- Well-woman care visits to a gynecologist/obstetrician.
- Women with no prior or family history of breast cancer are covered for a baseline mammogram between ages 35-39, and an annual mammogram at age 40 and over. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one.
- Women's contraceptives, sterilization procedures, and counseling: This includes contraceptive devices such as diaphragms, intra uterine devices ("IUDs"), and implants, as well as injectable contraceptives.
- Breastfeeding support, supplies, and counseling: Covered in full when received from an In-Network Provider. Benefits for breast pumps are limited to one pump per pregnancy.
- Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

The preventive services referenced above shall be covered in full when received from In-Network Providers. Cost-sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

The Fund's coverage of preventive services is intended to comply with all the requirements of the Affordable Care Act. Under this law, there may occasionally be changes to the preventive services that are required to be covered. The Fund will comply with any such changes in the preventive service coverage requirements. A list of the preventive services covered under the Fund is available at **www.healthcare.gov** or **www.empireblue.com,** or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

What's Covered

For Adults

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Depression screening
- Diabetes (Type 2) screening for adults with high blood pressure

- Diet counseling for adults at higher risk for chronic disease
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence
- Hepatitis C screening for adults at increased risk, and one time for everyone born between 1945 and 1965
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- Immunization vaccines for adults — doses, recommended ages, and recommended populations vary:
    - Diphtheria
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus (HPV)
    - Influenza (flu shot)
    - Measles
    - Meningococcal
    - Mumps
    - Pertussis
    - Pneumococcal
    - Rubella
    - Tetanus
    - Varicella (Chickenpox)
- Lung cancer screening for adults ages 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit smoking in the past 15 years
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users

For Pregnant Women or Women who may become Pregnant

- Anemia screening on a routine basis
- Breastfeeding comprehensive support and counseling from trained Providers, and access to breastfeeding supplies, for pregnant and nursing women
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care Provider for women with reproductive capacity (not including abortifacient drugs)
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Urinary tract or other infection screening

Other Covered Preventive Services for Women

- Breast cancer genetic test counseling (BRCA) for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention counseling for women at higher risk
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Domestic and interpersonal violence screening and counseling for all women
- Gonorrhea screening for all women at higher risk
- HIV screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors

- Rh incompatibility screening follow-up testing for women at higher risk
- Sexually transmitted infections counseling for sexually active women
- Syphilis screening for women at increased risk
- Tobacco use screening and interventions
- Well-woman visits to get recommended services for women under 65

Coverage for Children's Preventive Health Services

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Cervical dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under age 3
- Dyslipidemia screening for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 – 17 years
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns

- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis (Whooping Cough)
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (PVU)
    - Inactivated Poliovirus
    - Influenza (flu shot)
    - Measles
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella (Chickenpox)
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Obesity screening and counseling
- Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Vision screening for all children

In addition to the above-listed free preventive services, there is no cost-sharing for diagnostic testing related to COVID-19 (either for a COVID-19 test or an antibody test) or for the in-network visit associated with such testing, whether at a doctor's office, urgent care center, or hospital. Although there is no cost-sharing for In-Network or Out-of-Network testing, it is recommended that you remain In-Network when possible.

What's Not Covered

The following is a partial listing of preventive services not covered:

- Screening tests done at your place of work at no cost to you
- Free screening services offered by a government health department
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests

The preventive services referenced above will be covered in full when received from In-Network Providers. Cost-sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

Emergency and Urgent Care

What's Covered

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:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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.

You are responsible for the emergency room Copayment ($200) for a visit to an emergency room if your out-of-pocket maximum has not been met. The emergency room Copayment is waived if you are admitted to the Hospital within 24 hours. You will need to show your identification card when you arrive at the emergency room. If you make an emergency visit to your PCP's office, you pay the same Copayment as for an office visit. See the ***Schedule of Benefits*** starting on page 41 for Copayment amounts.

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

What's Not Covered

These emergency services are not covered:

- Use of the Emergency Room:
  - To treat routine ailments;
  - Because you have no regular physician; or
  - Because it is late at night or on a weekend or holiday (and the need for treatment is not sudden and serious).
- Ambulette.

Emergency Air Ambulance

Empire will provide In-Network coverage for air ambulance services when needed to transport you to the nearest acute care Hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care, subject to cost-sharing obligations, when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health; and
- Services are covered to transport you from one acute care Hospital to another, only if the transferring Hospital does not have adequate Facilities to provide the Medically Necessary services needed for your treatment as determined by Empire and use of land ambulance would pose an immediate threat to your health.

If Empire determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by land ambulance to the nearest acute care Hospital, the Fund will only pay up to the amount that would be paid for land ambulance to that Hospital. You may be required to pay the difference between the Allowed Amount and the total charges of an Out-of-Network Provider.

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

Emergency Land Ambulance

The Fund will provide coverage for land ambulance transportation to the nearest acute care Hospital, in connection with emergency room care or emergency inpatient admission, provided by an ambulance service, when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with a condition in serious jeopardy, or, for behavioral condition, placing the health of the person or others in serious jeopardy;
- Serious impairment to a person's bodily functions;
- Serious dysfunction of any bodily organ or part of a person; or
- Serious disfigurement to the person.

Benefits are not available for transfers between healthcare Facilities.

Urgent Care

Urgent care is care required in order to prevent serious deterioration to your health. It is the type of care that requires timely attention (i.e., bronchitis, high fever, sprained ankle), but is not an emergency. Urgent care is covered in an urgent care center or in your physician's office.

For urgent care, you may receive In-Network or Out-of-Network Benefits. If you visit an In-Network doctor or urgent care center, you must pay a Copayment. If you visit an Out-of-Network doctor or urgent care center, you pay a Deductible and Coinsurance.

Maternity Care and Infertility Treatment

If You Are Having a Baby

- You pay a Deductible and Coinsurance for maternity and newborn care when you use Network Providers. This includes routine tests related to pregnancy, obstetrical care in the Hospital or birthing center, as well as routine newborn nursery care; and
- For Out-of-Network maternity services, you pay the Deductible, Coinsurance and any amount above the Allowed Amount. The Fund's reimbursements for maternity services may be consolidated in up to three installments, as follows:
    - Two payments for prenatal care, and
    - One payment for delivery and post-natal care.

What's Covered

Covered Services are listed in the ***Schedule of Benefits*** starting on page 41. The 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;
- Services of a certified nurse-midwife affiliated with a licensed Facility. The nurse-midwife's services must be provided under the direction of a physician;
- Parent education, and assistance and training in breast or bottle feeding, if available;
- Circumcision of newborn males;
- Special care for the baby if the baby stays in the Hospital longer than the mother; and
- Semi-private room.

What's Not Covered

These maternity care services are not covered:

- Days in Hospital that are not Medically Necessary (beyond the 48-hour/96-hour limits);
- Services that are not Medically Necessary;
- Private room;
- Out-of-Network birthing center Facilities; and
- Private duty nursing.

Newborns' and Mothers' Health Protection Act of 1996

The Fund generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 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 or 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, the Fund may not, under Federal law, require that a Provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Infertility Treatment

Infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse. The following are Covered Services and limitations that include medical and surgical procedures, such as:

- Artificial insemination;
- Intrauterine insemination; and
- Dilation and curettage (D&C), including any required inpatient or outpatient Hospital care that would correct malformation, disease or dysfunction resulting in infertility; and services in relation to diagnostic tests and procedures necessary to determine infertility; or
- In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:
    - Hysterosalpingogram,
    - Hysteroscopy,
    - Endometrial biopsy,
    - Laparoscopy,
    - Sono-hysterogram,
    - Post-coital tests,
    - Testis biopsy,
    - Semen analysis,
    - Blood tests,
    - Ultrasound, and
    - Other Medically Necessary diagnostic tests and procedures, unless excluded by law.

Services must be Medically Necessary and must be received from eligible Providers as determined by Empire. In general, an eligible Provider is defined as a health care Provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

Prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility, which are not related to any excluded services, may be covered under the prescription drug benefits. See the *Prescription Drug Program* starting on page 94 for more information.

What's Not Covered

The Fund will not cover any services related to or in connection with:

- In-vitro fertilization;
- Gamete intra-fallopian transfer (GIFT);
- Zygote intra-fallopian transfer (ZIFT);
- Reversal of elective sterilizations, including vasectomies and tubal ligations;
- Sex-change procedures;
- Cloning; or
- Medical or surgical services or procedures that are experimental to diagnose or treat infertility if Empire determines, in Empire's sole judgment, that the service was not Medically Necessary.

Hospital Services

If You Visit the Hospital

The Fund covers most of the cost of your Medically Necessary care when you stay at a Network Hospital for surgery or treatment of Illness or Injury. When you use an In-Network Hospital or Facility, you pay the In-Network Deductible and Coinsurance. When you use an Out-of-Network Hospital or Facility, you pay the Out-of-Network Deductible and Coinsurance, plus any amount above Empire's Allowed Amount.

You are also covered for 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.

When you use a Network Hospital, you will not need to file a claim in most cases. When you use an Out-of-Network Hospital, you may need to file a claim.

Pre-Surgical Testing

Benefits are available for pre-surgical testing on an outpatient basis when performed at the Hospital where the surgery is scheduled to take place, if:

- Reservations for a Hospital bed and an operating room at that Hospital have been made prior to performance of the tests;
- Your doctor has ordered the tests; and
- Proper diagnosis and treatment require the tests.

The surgery must take place within seven days after these tests. If surgery is canceled because of these pre-surgical test findings or as a result of a voluntary second opinion on surgery, the Fund will still cover the cost of these tests, but they will not be covered when the surgery is canceled for any other reason.

Inpatient and Outpatient Hospital Care

What's Covered

Covered Services are listed in the *Schedule of Benefits* starting on page 41. The following are additional Covered Services and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies;
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration);
- Anesthesiologist, including one consultation before surgery and services during and after surgery;

- Blood and blood derivatives for emergency care, Same-Day Surgery, or Medically Necessary conditions, such as treatment for hemophilia; and
- MRIs/MRAs, PET/CAT scans and nuclear cardiology services.

Inpatient Hospital Care

What's Covered

Following are additional Covered Services for inpatient care:

- Semi-private room and board when
  - The patient is under the care of a physician, and
  - A Hospital stay is Medically Necessary;
- Coverage is for unlimited days, unless otherwise specified;
- Operating and recovery rooms;
- Special diet and nutritional services while in the Hospital;
- Cardiac care unit;
- Services of a licensed physician or surgeon employed by the Hospital;
- Care related to surgery; and
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery,
  - Surgery on the other breast to produce a symmetrical appearance,
  - Prostheses, and
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas.
  - The patient has the right to decide, in consultation with the physician, the length of Hospital stay following mastectomy surgery.
- Bariatric Surgery
  - Based on Medical Necessity and medical policy.
- Use of cardiographic equipment;
- Drugs, dressings and other Medically Necessary supplies;
- Social, psychological and pastoral services;
- Reconstructive surgery associated with Injuries unrelated to cosmetic surgery;
- Reconstructive surgery for a functional defect which is present from birth;
- Physical, occupational, speech and vision therapy including Facilities, services, supplies and equipment; and
- Facilities, services, supplies and equipment related to Medically Necessary medical care.

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

Women's Health and Cancer Rights Act of 1998

This federal law imposes certain requirements on plans that provide medical and surgical benefits with respect to a mastectomy. Specifically, in the case of an individual who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the law requires coverage for:

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

The coverage described above will be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to all coverage terms and limitations (for example,

Deductibles and Coinsurance) consistent with those established for the Fund's other benefits.

Outpatient Hospital Care

What's Covered

The following are additional Covered Services for same-day care:

- Same-day and Hospital outpatient surgical Facilities;
- Surgeons;
- Surgical assistant if:
    - None is available in the Hospital or Facility where the surgery is performed, and
    - The surgical assistant is not a Hospital employee;
- Chemotherapy and radiation therapy, including medications, in a Hospital outpatient department, doctor's office or Facility. Medications that are part of outpatient Hospital treatment are covered if they are prescribed by the Hospital and filled by the Hospital pharmacy; and
- 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 and its 30-month coordination period has expired:
    - 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), and
    - In a Hospital-based or free-standing Facility. See "Hospital/Facility" in the ***Glossary*** section.

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

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

- Private duty nursing;
- Private room. If you use a private room, you pay the difference between the cost for the private room and the Hospital's average charge for a semiprivate room. The additional cost cannot be applied to your Deductible or Coinsurance;
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated 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),
    - Spas,
    - Sanitariums, and
    - Infirmaries at schools, colleges or camps;
- Any part of a Hospital stay that is primarily custodial;

- Elective cosmetic surgery or any related complications; and
- 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 *Glossary* section.

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

- Same-Day Surgery not pre-certified as Medically Necessary by Empire's Medical Management Program; and
- Routine medical care including but not limited to:
    - Inoculation or vaccination,
    - Drug administration or injection, excluding chemotherapy, and
    - Collection or storage of your own blood, blood products, semen or bone marrow.

Durable Medical Equipment and Supplies

The Fund covers the cost of Medically Necessary prosthetics, orthotics and durable medical equipment from network suppliers only. In-Network Benefits and plan maximums are shown in the *Schedule of Benefits* starting on page 41. Out-of-Network Benefits are not available.

An Empire network supplier may not bill you for Covered Services. If you receive a bill from one of these Providers, contact Empire's Member Services at 844-416-6387.

Disposable medical supplies, such as syringes, are covered up to the Allowed Amount whether you obtain them In- or Out-of-Network.

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available both In- and Out-of -Network.

What's Covered

Covered Services are listed in the *Schedule of Benefits* starting on page 41. The following are additional Covered Services and limitations:

- Prosthetics, orthotics and durable medical equipment from network suppliers, including:
    - Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses,
    - Prescription lenses, if organic lens is lacking,
    - Supportive devices essential to the use of an artificial limb,
    - Corrective braces,
    - Wheelchairs, Hospital-type beds, oxygen equipment, sleep apnea monitors;
- Rental (or purchase when more economical) of Medically Necessary durable medical equipment;
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician;
- Reasonable cost of repairs and maintenance for covered medical equipment;
- Enteral formulas with a written order from a physician or other licensed health care Provider. The order must state that:
    - The formula is Medically Necessary and effective, and
    - Without the formula, the patient would become malnourished, suffer from serious physical disorders or die; and

- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare Provider must provide a written order.

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

What's Not Covered

The following equipment is not covered:

- Air conditioners or purifiers;
- Humidifiers or dehumidifiers;
- Exercise equipment;
- Swimming pools;
- False teeth; and
- Hearing aids (while this is excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide coverage for hearing exams and hearing aids; see page 117 to learn more about the Fund's hearing benefits).

Skilled Nursing and Hospice Care

Benefits are available for Network Facilities only. Benefits and plan maximums are shown in the ***Schedule of Benefits*** starting on page 41.

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

Skilled Nursing Care

What's Covered

You are covered for inpatient care in a Network skilled nursing Facility if you need medical care, nursing care or rehabilitation services. The number of covered days is listed in the ***Schedule of Benefits*** starting on page 41. 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; and
- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other healthcare professional.

What's Not Covered

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, and
    - Rest cures.

Hospice Care

Empire 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 12 months or less. Hospice care can be provided in a hospice, in the hospice area of a Network Hospital, or at home, as long as it is provided by a Network hospice agency.

What's Covered

Covered Services are listed in the ***Schedule of Benefits*** starting on page 41. The following are additional Covered Services and limitations:

- Hospice care services, including:
    - 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, and
    - 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 skilled nursing Facility. You receive coverage only when you use a Network Provider. Benefits and plan maximums are shown in the ***Schedule of Benefits*** starting on page 41.

Home infusion therapy, a service sometimes provided during home health care visits, is only available In-Network. An Empire Network home health care agency or home infusion supplier cannot bill you for Covered Services. If you receive a bill from one of these Providers, contact Empire's Member Services at 844-416-6387.

What's Covered

Covered Services are listed in the ***Schedule of Benefits*** starting on page 41. The following are additional Covered Services and limitations:

- Up to 200 home health care visits per year, In-Network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours per day (three visits). Your physician must certify home health care as Medically Necessary and approve a written treatment plan; and
- Home health care services include:
    - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN),
    - Part-time home health aide services (skilled nursing care),
    - Physical, speech or occupational therapy, if restorative,
    - Medications, medical equipment and supplies prescribed by a doctor, and
    - Laboratory tests.

What's Not Covered

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care; and
- Out-of-Network home health care visits and home infusion therapy.

Physical, Occupational, Speech or Vision Therapy

Outpatient and inpatient physical therapy, occupational, speech and vision therapy services are available In-Network only. Please refer to the ***Health Management*** section for details regarding precertification requirements.

What's Covered

Covered services are listed in the ***Schedule of Benefits*** starting on page 41. The following are additional Covered Services and limitations:

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an inpatient or outpatient basis up to the Plan maximums if:
    - Prescribed by a physician, and
    - Designed to improve or restore physical functioning within a reasonable period of time.

Outpatient care must be given at home, in a therapist's office or in an outpatient Facility by a Network Provider; inpatient therapy must be short-term. In the case of speech or vision therapy, such therapy must be provided by a licensed speech/language pathologist or audiologist.

What's Not Covered

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities; and
- Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy.

Exclusion of Benefits Recoverable Under Third-Party Actions

If you require medical care treatment as a result of a motor vehicle accident, all claims for service must be submitted to your motor vehicle insurance. If your insurance carrier does not pay your total medical expenses incurred in the accident, a claim may then be submitted to the Fund for the amount not covered by the insurance carrier, together with a denial or letter of exhaustion of benefits. The amount of the Fund's payment will be determined based on the Plan's rules. Amounts paid by the Fund for injuries sustained in third-party actions are subject to the Fund's Subrogation and Reimbursement rules described later in this SPD.

Behavioral Healthcare and Substance Abuse

The Fund provides In-Network and Out-of-Network benefits for: inpatient and outpatient treatment for behavioral/mental health services and alcohol or substance abuse, inpatient detoxification, inpatient alcohol

and substance abuse rehabilitation in a Facility, and inpatient and outpatient mental health care on an inpatient and outpatient basis.

Members Education and Network for Dependency ("MEND") Program

If you wish to obtain access to confidential treatment for alcohol or substance abuse, contact the MEND Program by phone at **(212) 366-7590** or by email at **MEND@nyccbf.org**. MEND is located at 395 Hudson Street, 5th Floor, New York, NY 10014.

MEND handles all level of care determinations, authorizations, utilization reviews, and case management services for Actives and Pre-Medicare-Eligible Retirees.

Mental Health Care

What's Covered

In addition to the services listed in the ***Schedule of Benefits*** starting on page 41, the following mental health care services are covered:

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if pre-certified by Empire;
- 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; and
- Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders or comparably licensed organization in another state.

What's Not Covered

The following mental health care services are not covered:

- Care that is not Medically Necessary.

Treatment for Alcohol or Substance Abuse

What's Covered

In addition to the services listed in the ***Schedule of Benefits*** starting on page 41, the following services are covered:

- Family counseling services at an outpatient treatment Facility. These can take place before the patient's treatment begins. Any family member covered by the Fund may receive Medically Necessary counseling visits; and
- Out-of-Network outpatient treatment at a Facility that:
    - Has New York State certification from the Office of Alcoholism and Substance Abuse Services, and
    - 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.

What's Not Covered

The following alcohol and substance abuse treatment services are not covered:

- Out-of-Network outpatient alcohol or substance abuse treatment at a Facility that does not meet Empire's certification requirements as stated above and,
- Care that is not Medically Necessary.

Exclusions and Limitations

Exclusions

In addition to services mentioned under ***What's Not Covered*** in the prior sections, the Fund does not cover the following:

Dental Services

Dental services, including but not limited to:

- Cavities and extractions;
- Care of gums;
- Bones supporting the teeth or periodontal abscess;
- Orthodontia;
- False teeth;
- Treatment of TMJ that is dental in nature; and
- Orthognathic surgery that is dental in nature.

However, the Fund does cover:

- Surgical removal of impacted teeth; and
- Treatment of sound natural teeth injured by accident.

While Dental Services are excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide dental coverage through the ASO/SIDS; see the ***Dental Benefits*** section starting on page 105 for more information.

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:
    - Experimental or investigative, or
    - Obsolete or ineffective;
- Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that, for the particular diagnosis or treatment of the covered person's condition, the treatment is:
    - Not of proven benefit, or
    - Not generally recognized by the medical community (as reflected in published medical literature); and
- Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is not experimental, investigative, obsolete or ineffective:

- There is final market approval by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met,
- Published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes,
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects), and
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

Gene Therapy

- Any and all charges for, or related to, gene therapy treatments, whether those therapies have received approval from the FDA or not, or are considered experimental or investigational. For example, this exclusion applies to Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well and Luxturna and Zolgensma, and to all new gene therapies that become available. This exclusion applies regardless of whether the treatments, services or charges fall under the Medical/Hospital Plan or the Prescription Plan.

Government Services

- Services covered under government programs, except Medicaid or where otherwise noted; and
- Government Hospital services, except:
  - Specific services covered in a special agreement between Empire and a government Hospital, and
  - United States Veterans' Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, the Fund 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 SPD as available either at home or as an emergency.

Inappropriate Billing

- Services usually given without charge, even if charges are billed; and
- Services performed by Hospital or institutional staff that are billed separately from other Hospital or institutional services, except as specified.

Medically Unnecessary Services

- Services, treatment or supplies not Medically Necessary in Empire's judgment. See ***Glossary*** section for more information.

Prescription Drugs

- All prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated (While Prescription Drugs are excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide Prescription Drug coverage separately. Please see the ***Prescription Drug*** Program section starting on page 94 for more information.)

Sterilization/Reproductive Technologies

- Reversal of sterilization; and
- Assisted reproductive technologies including but not limited to:
    - In-vitro fertilization,
    - Gamete and zygote intrafallopian tube transfer, and
    - Intracytoplasmic sperm injection.

Travel

- Travel, even if associated with treatment and recommended by a doctor.

Vision Care

- Eyeglasses, contact lenses, and the examination for their fitting except following cataract surgery, unless specifically indicated (While Vision Care Services are excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide Vision Care Benefits; see page 115 for information about the Vision Care Benefits).

War

- Services for Illness or Injury received as a result of war.

Workers' Compensation

Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

Limitation as Independent Contractor

The relationship between Empire and Hospitals, Facilities, or Providers is that of independent contractors. Nothing in this SPD or any other document shall be deemed to create between the Fund and Empire, on one hand, and any Hospital, Facility or Provider (or agent or employee thereof), on the other hand, the relationship of employer and employee or of principal and agent. Neither the Fund nor Empire will 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.

HEALTH MANAGEMENT

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 Fund will pay. To help you manage your health, Empire's Medical Management Program pre-certifies 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.

You can contact Empire's Medical Management program by calling Empire's Member Services at 844-416-6387 or the 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;
- Coordinates purchase and replacement of durable medical equipment, prosthetics and orthotic requirements;
- Reviews inpatient and **Ambulatory Surgery**;
- Reviews high-risk maternity admissions; and
- 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 pre-certified with Empire's Medical Management Program.

FOR ALL HOSPITAL ADMISSIONS

- 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; and
- Before you are admitted to a rehabilitation Facility or a skilled nursing Facility.

BEFORE YOU RECEIVE/USE

- Inpatient Mental Health Care, Substance Abuse Care, and Alcohol Detoxification;
- Partial Hospital Programs, Intensive Outpatient Programs for Mental Health Care, and Substance Abuse Care;
- Outpatient treatment for Mental Health Care and Substance Abuse Care;
- Occupational, physical, speech, and vision therapy;
- Outpatient/Ambulatory Surgical Treatments (Certain outpatient services require precertification. Before you schedule a procedure, ask your provider to contact Empire's Medical Management at 844-416-6387 to see if that procedure requires precertification. Failure to pre-certify may result in a penalty and/or denial of the claim if the service is not deemed to be medically necessary.);
- High-tech radiology services: MRI, MRA, PET, CAT, CTA, MRS, CT/PET, SPECT, ECHO Cardiology, Nuclear Technology services;
- Diagnostics;
- Outpatient Treatments;
- Durable medical equipment, prosthetics, orthotics; and
- Air ambulance.

If Services Are Not Pre-certified

If you call to pre-certify services where required, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure. This benefit reduction also applies to certain Same-Day Surgery and professional services rendered during an inpatient admission. If the admission or procedure is not Medically Necessary, no benefits will be paid. In addition, any out-of-pocket amount that you pay due to a failure to pre-certify does not count in reaching your out-of-pocket annual limit.

Initial Decisions

Empire will comply with the following time frames in processing precertification, concurrent and retrospective review of requests for services. The outcome of a decision may result in your eligibility to appeal the decision according to the *Grievances and Appeals* section explained on page 148.

- ***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 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 a 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 Empire's receipt of the request. If the request is urgent and Empire requires further information to make a 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 Empire's 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 Empire's 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 Empire's 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 a Request/Claim Is Denied

Benefit denials for lack of medical necessity will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity, or because the service has been determined to be experimental or investigational, Empire's Medical Management Program will notify you and your doctor of the reasons for the denial. You will have the right to appeal. (See the *Grievances and Appeals* section for more information.)

If Empire's Medical Management Program denies benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Empire's Medical Management Program to reconsider its decision. A response will be provided by phone and in writing within one business day of making a decision.

New Medical Technology

Requesting Coverage

Empire uses a committee composed of Empire Medical Directors, who are doctors and Participating Network Physicians, to continuously evaluate new medical technology that has not yet been designated as a covered service. If you want to request certification of a new medical technology before beginning treatment, your Provider must contact Empire's Medical Management Program. The Provider will be asked to do the following:

- Provide full supporting documentation about the new medical technology;
- Explain how standard medical treatment has been ineffective or would be medically inappropriate; and
- Send Empire scientific peer-reviewed literature that supports the effectiveness of this particular technology. The literature must not be in the form of an abstract or individual case study.

Empire's staff will evaluate the proposal in light of the Fund's contract and Empire's current medical policy. Empire will review the proposal, taking into account relevant medical literature, including current peer-reviewed articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will send all decisions to you and/or your Provider.

Case Management

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. Empire's nurses can help you and your family:

- Find appropriate, cost-effective healthcare options;
- Reduce medical cost; and
- Assure quality medical care.

A Case Manager serves as a single source for patient, Provider, and the Fund – assuring 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; and
- Spinal cord and other traumatic Injuries.

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Empire's 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 Fund is desirable, appropriate and cost-effective. If you would like Case Management assistance following an Illness or surgery, contact Empire's Medical Management Program at 844-416-6387.

Residential Treatment Program

The Fund provides coverage for treatment in Residential Treatment Programs as explained below.

Residential treatment is defined as specialized treatment that occurs in a residential treatment center. These facilities are typically designated residential, subacute, or intermediate care facilities and may occur in care systems that provide multiple levels of care. Residential treatment is 24 hours per day and requires a minimum of one physician visit per week in a Facility-based setting. Wilderness programs are not considered residential treatment programs.

To qualify, your symptoms or condition must meet the diagnostic criteria for a Diagnostic and Statistical Manual of Mental Disorders ("DSM") or International Classification of Diseases ("ICD"). Diagnosis that is consistent with symptoms and the primary focus of treatment is residential treatment center ("RTC") psychiatric care. All services must be Medically Necessary.

Severity of Illness ("SI")

You must have all of the following to qualify:

- You are manifesting symptoms and behaviors which represent a deterioration from your usual status and include either self-injurious or risk-taking behaviors that risk serious harm and cannot be managed outside of a 24-hour structured setting or other appropriate outpatient setting; and
- Your social environment is characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while you are in the residential Facility; and
- There should be a reasonable expectation that the Illness, condition or level of functioning will be stabilized and improved and that a short-term, subacute residential treatment service will have a likely benefit on the behaviors/symptoms that required this level of care, and that you will be able to return to outpatient treatment.

Intensity of Service ("IS")

You must have all of the following to qualify:

- Residential treatment takes place in a structured Facility-based setting. Wilderness programs are not considered residential treatment; and
- Documentation shows that a blood or urine drug screen was done on admission and during treatment if indicated; and
- Evaluation by a qualified physician within 48 hours, and physical exam and lab tests unless done prior to admission, and eight-hour on-site nursing (by either a registered nurse ["RN"] or licensed vocational nurse/licensed practical nurse ["LVN"/ "LPN"]) with 24-hour medical availability to manage medical problems if medical instability is identified as a reason for admission to this level of care; and
- Within 72 hours, a multidisciplinary assessment with an individualized problem-focused treatment plan completed, addressing psychiatric, academic, social, medical, family and substance use needs; and

- Coordination of care with other clinicians, such as the outpatient psychiatrist, therapist, and your PCP, providing treatment to you, and where indicated, clinicians providing treatment to other family members, is documented; and
- Treatment would include the following at least once a day and each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy; and
- Skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability; and
- Individual treatment with a qualified physician at least once a week including medication management if indicated; and
- Individual treatment with a licensed behavioral health clinician at least once a week; and
- Unless contraindicated, family members participate in development of the treatment plan, participate in family program and groups and receive family therapy at least once a week, including in-person family therapy at least once a month if the Provider is not geographically accessible. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated; and
- A discharge plan is completed within one week that identifies the outpatient Providers and where you will reside; and
- The treatment is individualized and not determined by a programmatic time frame. It is expected that you will be prepared to receive the majority of treatment in a community setting; and
- Medication evaluation and documented rationale if no medication is prescribed.

Continued Stay Criteria ("CS")

You must continue to meet "SI/IS" Criteria and have the following to qualify:

- SI criteria are still met and likelihood of benefit and return to outpatient ("OP") treatment is shown by adherence to the treatment plan and recommendations by you and by progress in treatment; if progress is not occurring, then the treatment plan is being amended in a timely and medically appropriate manner with treatment goals still achievable.

Not Medically Necessary

Residential treatment center psychiatric care is considered not Medically Necessary when the above criteria are not met.

REIMBURSEMENT FOR COVERED SERVICES

Allowed Amount or Maximum Allowed Amount

This section describes how Empire determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on the Allowed Amount for the Covered Service that you receive. Please see the BCBS BlueCard Program section for additional information regarding services received outside of Empire's service area. Note that the terms "Allowed Amount" and "Maximum Allowed Amount" may be used interchangeably.

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

- that meet the definition of Covered Services, to the extent such services and supplies are covered;
- that are Medically Necessary; and
- that are provided in accordance with all applicable precertification, Medical Management Programs or other applicable requirements.

You will be required to pay a portion of the Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you will be responsible for any difference between the 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 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 the determination of the Allowed Amount. Empire's 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 procedure coding rules and/or its 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 Allowed Amount will be based on the single procedure code rather than a separate 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 Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Network Status

The Allowed Amount will vary depending upon whether the Provider/Hospital/Facility is In-Network or Out-of-Network.

For Covered Services performed by an In-Network Provider/Hospital/Facility, the Allowed Amount is the rate the Provider/Hospital/Facility has agreed with Empire to accept as reimbursement for the Covered Services. Because In-Network Providers/Hospitals/Facilities have agreed to accept the Allowed Amount as payment in full for that service, they should not bill you or seek to collect amounts above the Allowed Amount. However, you may be billed or be asked to pay all or a portion of the Allowed Amount to the extent that you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider/Hospital/Facility or visit **www.empireblue.com**.

Providers/Hospitals/Facilities who have not signed any contract with Empire and are not in any of Empire's networks are Out-of-Network, subject to BCBS Association rules governing claims filed by certain ancillary Providers.

The Allowed Amount for Covered Services from an Out-of-Network Provider is the lesser of the Out-of-Network Provider's charge or 250% of the reimbursement rate used by the Centers for Medicare and Medicaid Services ("CMS"), unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually.

If there is no reimbursement rate used by CMS for Covered Services that you receive from an Out-of-Network Provider, the Allowed Amount is the lesser of the Out-of-Network Provider's charge or Empire's Out-of-Network Provider fee schedule/rate which has been developed by reference to one or more of several sources, including the following:

- Amounts based on Empire's In-Network Provider fee schedule/rate;
- Amounts based on charge, cost reimbursement or utilization data; or
- 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.

Providers who are not contracted for the Fund, but who are contracted for other plans with Empire, are also considered Out-of-Network. The Allowed Amount for services from these Providers will be based on Empire's Out-of-Network Provider fee schedule/rate as described above unless the contract between Empire and that Provider specifies a different amount.

The Allowed Amount for Covered Services from an Out-of-Network Hospital or Facility in Empire's Network service area will be the average amount paid by Empire for comparable services to Empire's Participating Hospitals/Facilities in the same county. If there are no like-kind Participating Hospitals/Facilities in the same county, then the Allowed Amount will be the average of amounts paid by Empire for comparable services to like-kind Participating Hospitals/Facilities in the contiguous county or counties.

The Allowed Amount for Covered Services that you receive from non-participating Facilities outside of Empire's Network service area will be the average amount paid by Empire for comparable services to Empire's Participating Hospitals/Facilities in a service area county designated by Empire. If there are no like kind Participating Hospitals and/or Facilities in that county, then the average of amounts paid by Empire for comparable services in like kind Participating Hospitals and/or Facilities in the closest county to the designated county will be used.

Unlike In-Network Providers/Hospitals/Facilities, Out-of-Network Providers/Hospitals/Facilities (1) may bill you and seek to collect the amount of the Provider's/Hospital's/Facility's charge that exceeds the Allowed Amount, and (2) may sue you to collect the difference between the Allowed Amount and their charges, which can be very significant. You are responsible for paying the difference between the Allowed Amount and the amount the Provider/Hospital/Facility charges. This amount can be significant. The Fund has no responsibility to pay any difference between the Allowed Amount and the amount the Provider/Hospital/Facility charges. Choosing an In-Network Provider/Hospital/Facility will likely lower your out-of-pocket costs. Please call Customer Service for help in finding In-Network Providers/Hospitals/Facilities or visit Empire's website at **www.empireblue.com**.

Customer Service is available to assist you in determining the Allowed Amount for a particular service from an Out-of-Network Provider/Hospital/Facility. In order to assist you, you will need the specific procedure codes and diagnosis codes for the services at issue and the Provider's/Hospital's/Facility's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Allowed Amount for your claim will be based on the actual claim submitted.

Your Cost Share

You may be required to pay a part of the Allowed Amount as your cost-share amount (for example, Deductible, Copayment and/or Coinsurance) for certain Covered Services.

Your cost-share amount and out-of-pocket maximums may vary depending on whether you received services from an In-Network or an Out-of-Network Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the *Glossary* and *Schedule of Benefits* chart for your cost-share amounts and limitations or call Customer Service to learn how the Fund's benefits or cost-share amounts may vary by the type of Provider you use.

The Fund does not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non-Covered Services regardless of whether such services are performed by an In-Network Provider or an Out-of-Network Provider. Both services specifically excluded and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your benefit caps, or day/visit limits. Note that no Out-of-Network coverage is available for benefits that are listed in this SPD as In-Network only.

In some instances, you may only be asked to pay the lower In-Network cost-sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost-share amounts for those Covered Services. However, you also may be liable for the difference between the Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, Empire may authorize the In-Network cost-share amounts (Deductible, Copayment and/or

Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact Empire in advance of obtaining the Covered Service. Empire will authorize the In-Network cost-share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider consistent with applicable regulations on Emergency Services. If Empire authorizes an Out-of-Network Covered Service so that you are responsible for the In-Network cost-share amounts, you may still be liable for the difference between the Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service at 844-416-6387 for information or to request authorization.

LIVEHEALTH ONLINE

Coverage for Online Visits

Online visits. Your coverage includes online physician office visits. Covered Services include a visit with the physician using the internet via a webcam with online chat or voice functions. Services are provided by board-certified, licensed Primary Care Physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

Cost: $10 per online visit.

Member Access. To begin the online visit, log on to **www.livehealthonline.com** and establish an online account by providing basic information about you and the Plan. Before you connect to a doctor, you will be asked to: identify the kind of condition you want to discuss with the doctor, list your local pharmacy, provide information for the credit card you want your cost share for the visit to be billed to, agree to the terms of use, and select an available physician. If you are not in New York State when you seek an online visit, you will need to check whether an online doctor is available in your state because online doctors are not available in every state.

Your visit will not start until you provide the above information and click "connect." The visit will be documented in an electronic health record. You may access and print your records to provide them to your Primary Care Physician.

Note about Covered Services. Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist;
- To request Preauthorization for a benefit; or
- To ask the Physician to consult with another Physician.

MSK DIRECT

Guided Cancer Care and Treatment

The Fund has partnered with Memorial Sloan Kettering ("MSK") to bring you and your family members *MSK Direct*, a program that offers guided access to expert cancer care from a team of dedicated cancer specialists.

MSK Direct ensures access to a dedicated and compassionate team of cancer specialists. When facing cancer, getting the right diagnosis and care plan as early as possible is critical. Through *MSK Direct*, you have access to experienced nurses, social workers, and *MSK Direct* Care Advisors who guide you through the process of seeking care at MSK. They can facilitate prompt access to a doctor, including an appointment with an appropriate specialist at MSK within two business days of speaking with a representative. *MSK Direct* Care Advisors help you gather all necessary medical records and meet you at your first appointment to introduce you to the clinical team that will be handling your treatment.

You and your eligible dependents have access to *MSK Direct* at no additional cost beyond standard Copayments and Deductibles. Your family and friends can also utilize the services offered by *MSK Direct* (subject to them having health insurance coverage for care at MSK) should they need assistance.

MSK Direct is available to you even before you have a confirmed cancer diagnosis. You may contact *MSK Direct* if your doctor has recommended that you see an oncology provider or after a test that indicates a suspicion of cancer. If you have already been diagnosed with cancer, or are in treatment elsewhere, you can contact *MSK Direct* to schedule an appointment for a second opinion. Via *MSK Direct*, you have access to exceptional cancer care.

MSK Direct is available through the Fund's **dedicated toll-free *MSK Direct* phone line at 833-786-3368** from **Monday through Friday.** No enrollment is necessary to utilize *MSK Direct*.

PRESCRIPTION DRUG PROGRAM

The following sections describe the Fund's Prescription Drug Benefits that are provided under the **Active Level of Coverage and the Pre-Medicare Retiree Level of Coverage**.

Limitations on Benefits

The **Claims and Appeals for Prescription Benefits Administered by Express Scripts, and Your Rights Under the Employee Retirement Income Security Act of 1974** sections, which start on page 157, describe how to appeal a denial of benefits and the Fund's rules requiring that a lawsuit following denial of an appeal must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Prescription Drug Plan Works

The Fund provides coverage for prescription drugs purchased at participating retail pharmacies or through the mail-order pharmacy, which is mandatory for maintenance medications. Coverage depends on which option you use. Note that Pre-Medicare Retirees and their covered dependents will each have an annual deductible of $250.00.

You will receive an ID card when your coverage starts.

Express Scripts administers the Fund's prescription drug benefits and maintains the pharmacy network. The network currently includes Walgreens, CVS, Rite Aid, and other chain stores and independent pharmacies. To find a participating pharmacy near you:

- Visit **www.express-scripts.com** and click on "Locate a pharmacy;"
- Call Express Scripts Member Services at 800-939-2091 (available 24-hours a day, seven days a week, except on Christmas Day and Thanksgiving Day).

If you go to an Out-of-Network pharmacy (or if you go to an In-Network pharmacy but do not use your coverage at the time of purchase), you must pay the full cost when you pick up the prescription and then file a claim for reimbursement with Express Scripts. The Fund will pay you the discounted amount that would have been paid to a network pharmacy. You are responsible for any difference between the network discount price and what your pharmacy charged, plus the applicable Copayment. The Fund cannot under any circumstance provide benefits in excess of the network discount price. Claim forms are available from Express Scripts.

Because the difference between the network discount price and what your pharmacy charged can be significant, it is important to use In-Network pharmacies and to ensure that you have proof of coverage when you use an In-Network pharmacy.

If you or your eligible dependents were retroactively enrolled in the Fund and you purchased prescription drugs from In- Network or Out-of-Network pharmacies at a time when you otherwise would have been covered by the Fund, you must file a claim with Express Scripts for benefit consideration. As noted above, reimbursement is limited to the discount amount that would have been paid to an In-Network pharmacy. You are responsible for any difference between the In-Network

discount price and your actual cost, plus the applicable Copayment. The Fund cannot under any circumstance provide benefits in excess of the In-Network discount price.

Claim forms are available from Express Scripts.

The following table summarizes your prescription drug benefits.

Type of Drug	Retail Copay *Up to a 30-day supply*	Mail Order Copay *Up to a 90-day supply*
Preventive Medications	Plan pays 100%	Plan pays 100%
Generic	$15	$25
Preferred Brand Name	$25	$45
Non-Preferred Brand Name	$40	$75

To find out if a medication is preferred or non-preferred brand name, contact Express Scripts Member Services at 800-939-2091.

Out-of-Pocket Maximum Applicable to Your Covered Prescription Drug Expenses

The Fund limits your out-of-pocket expenses for covered services by having an annual out-of-pocket maximum. Once you have reached your annual out-of-pocket maximum, the Fund will begin paying 100% of your covered expenses until the end of the year.

The prescription drug out-of-pocket maximum for **Active Level of Coverage** is currently $3,000 per individual and $7,500 per family. The prescription drug out-of-pocket maximum for **Pre-Medicare Retiree Level of Coverage** is currently $3,250 per individual and $8,125 per family. The prescription drug out-of-pocket maximum is separate from the out-of-pocket maximum for medical and hospital benefits.

This out-of-pocket maximum is subject to change. In accordance with the ACA, the out-of-pocket maximum limit may be increased each year to account for health care inflation. The Fund will notify you of changes to the out-of-pocket maximums.

Only Copayments for in-network covered expenses will accumulate toward your annual prescription drug out-of-pocket maximum. You are still responsible for any other costs for non-covered expenses, including the difference in cost between a brand-name and a generic drug when you purchase a brand-name drug for which a generic drug is available.

Preventive Medications Covered at 100%

The Fund covers certain preventive prescription medications at 100%. There is no Copayment for the preventive prescription medications listed below. Express Scripts maintains the list of fully covered preventive medications. To determine whether a medication is on the list or to see the current list, you should visit **www.express-scripts.com** or call Express Scripts Member Services at 800-939-2091.

Here is what is currently covered at $0 Copayment for preventive services:

- Fluoride Supplements from 6 months of age through 5 years of age;
- Aspirin for Adults < 80 years old (Generic and OTC Products, < 325mg);
- Folic Acid;
- Smoking Cessation Products;
- Contraceptives for women through age 50;
- Preventive medications for breast cancer for women age 35 and older, including Tamoxifen (generic), Raloxifene (generic), and Soltamox (Tamoxifen liquid) (brand);
- Generic Bowel Prep Agents from age 50 through age 75;
- Vaccines;
- Vitamin D for ages 65 and older; and
- PrEP.

Additional Copayment for Brand-Name Drugs with Generic Equivalents

You pay a lower Copayment for preferred brand-name and generic drugs. These medications help control the cost of your prescription plan. Non-preferred brands cost you and the Fund more.

If you purchase a brand-name drug when a generic is available, you will pay the generic Copayment PLUS the difference in cost between the brand and the generic. Usually this will result in a Copayment greater than the standard Copayment for a non-preferred brand drug. This feature will apply whether you fill the prescription by mail or at a retail pharmacy and regardless of whether your physician writes the prescription as "Dispense as Written" (DAW). If your physician believes you must take the brand-name drug for medical reasons, ask your physician to request a review by contacting Express Scripts at 800-753-2851.

Mail-Order Program

If you take a medication on a long-term or continuous basis, you should use the mail-order program. Prescription medications that you take on a long-term or continuous basis are often referred to as maintenance medications and are taken every day for the treatment of a chronic condition, such as diabetes, asthma or high blood pressure. Once you have obtained a maintenance medication three times (the initial fill and two refills) at a retail pharmacy, you will be required to pay the entire cost if you continue to fill it at a retail pharmacy anytime thereafter. To avoid these costs, you should use the mail-order program to refill the prescription, which offers a greater discount on the cost of maintenance medication and a larger supply (90 days) per prescription.

If you fill a 90-day generic prescription through the mail-order program, the Copayment is $25. If you were to get the same amount of that generic medication at a retail pharmacy, it would cost you $45 because you would have to fill three 31-day prescriptions, each with a $15 Copayment. Using the mail-order program will save you $20.

More information about the mail-order program is available from Express Scripts at 800-939-2091 or **www.express-scripts.com**.

Smart 90 CVS

Active and Pre-Medicare Retirees and their covered dependents who are not utilizing the Medicare Part D Plan will be able to get a 3-month supply of long-term medications at a local participating CVS pharmacy.

For additional information or to locate a participating CVS near you, please contact Express Scripts at 800-939-2091 or **www.express-scripts.com/3month**.

Pre-certification

You must obtain precertification from Express Scripts in order to obtain coverage for certain prescription drugs. Your physician must call Express Scripts at 800-753-2851 to initiate the pre-authorization process for any of the prescription drugs listed in the table below.

Many of the prescription drugs that require pre-authorization are considered "specialty medications." Specialty medications are used to treat complex medical conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis. Specialty medications are costly, have special storage requirements and often require specialized patient training and coordination of care.

To obtain any specialty medication, you must use Express Scripts' specialty pharmacy, Accredo Health Group ("Accredo"). To reach the specialty pharmacy, call 800-803-2523. Your physician can also call the specialty pharmacy directly at 866-759-1557 (just give your doctor your 12-digit Express Scripts member identification number).

The following is a list of drugs that currently require pre-authorization. Generic forms of the prescription medications listed also require pre-authorization. The list of drugs requiring pre-authorization and those classified as specialty medications is subject to change. Contact Express Scripts at 800-753-2851 for up-to-date information.

Examples of Prescription Drugs that Require Pre-Authorization:	
Drug Category	**Drug Name**
ERYTHROID STIMULANTS	**Aranesp** (darbepoetin alfa) **Epogen** (epoetin alpha) **Procrit** (epoetin alpha)
GROWTH HORMONES	**Egrifta** (tesamorelin) **Genotropin** (somatropin) **Geref** (semorelin) **Humatrope** (somatropin) **Increlex** (mecasermin) **I-plex** (mecasermin) **Norditropin** (somatropin) **Nutropin** (somatropin) **Omnitrope** (somatropin) **Saizen** (somatropin) **Serostim** (somatropin) **Tev-Tropin** (somatropin) **Zorbtive** (somatropin)
GROWTH HORMONE RECEPTOR ANTAGONISTS	**Somavert** (pegvisomant)
MYELOID STIMULANTS	**Leukine** (sargramostim) **Neulasta** (pegfilgrastim) **Neumega** (oprelvekin) **Neupogen** (filgrastim) **Nplate** (romiplostim) **Promacta** (eltrombopag)
BOTULINUM TOXIN	**Botox** (Botulinum Toxin Type A) **Dysport** (abobotulinumtoxin A) **Myobloc** (Botulinum Toxin Type B) **Xeomin** (incobotulinunumtoxin A)
INTERFERONS	**Actimmune** (interferon gamma-1b) **Alferon-N** (interferon alpha-n3) **Infergen** (interferon alpha-con) **Intron-A** (interferon alpha-2b) **Pegasys** (Pegylated Interferon Alfa-2a) **Peg-Intron**, **Sylatron** (peginterferon alpha-2b)
ANTINARCOLEPTICS	**Nuvigil** (armodafinil) **Provigil** (modafinil)
ANTINEOPLASTICS (Miscellaneous Immunomodulatory)	**Revlimid** (lenalidomide) **Thalomid** (thalidomide)

Examples of Prescription Drugs that Require Pre-Authorization:	
Drug Category	**Drug Name**
FERTILITY AGENTS – For Non-Fertility Use	**Clomid** (clomiphene) **Serophene** (clomiphene) **Human Chorionic Gonadotropin (HCG**) Pregnyl, Novarel, Ovidrel **Gonadotropins** Menotropins (Repronex, Menopur) Urofollitropin (Bravelle) Follitropin alfa (Gonal-F) Follitropin beta (Follistim AQ) **Gonadotropin Releasing Hormone Agonist** leuprolide 1mg/0.2ml (Lupron) nafarelin (Synarel) **Progesterone** Crinone 8% (progesterone gel) Endometrin (progesterone) Prochieve 8% (progesterone gel)
DERMATOLOGICALS	**Atralin** (tretinoin) **Avita** (tretinoin) **Retin-A** (tretinoin) **Tazorac** (tazarotene) Tretinoins (generic) **Tretin-X** (tretinoin)
ANTIEMETICS	**Aloxi** (palonosetron) **Anzemet** (dolasetron) **Cesamet** (nabilone) **Kytril** (granisetron) **Sancuso** (granisetron) **Zofran, Zofran ODT** (ondansetron) **Zuplenz** (ondansetron)
RHEUMATOLOGICAL AGENTS	**Actemra** (tocilizumab) **Arava** (leflunomide) **Cimzia** (Certolizumab pegol) **Enbrel** (etanercept) **Humira** (adalimumab) **Kineret** (anakinra) **Orencia** (abatacept) **Remicade** (infliximab) **Rituxan** (rituximab) **Simponi** (golimumab)

Examples of Prescription Drugs that Require Pre-Authorization:	
Drug Category	**Drug Name**
CNS STIMULANTS	**Stimulants primarily used to treat Attention Deficit Hyperactivity Disorder (ADD/ADHD)**
SELECT SPECIALTY MEDICATIONS	**All new Specialty drugs that enter the market will be subject to Prior Authorization** **Acthar® H.P. gel (repository corticotropin injection)**
OPIOID DEPENDENCE	**Suboxone® (buprenorphine/naloxone)** **Zubsolv (buprenorphine/naloxone)**
NARCOTIC ANALGESICS	**Actiq** (fentanyl) **Fentora** (fentanyl)
HEPATITIS C	**Sovaldi (sofosvuvir)** **Olysio (simeprevir)**
NON-NARCOTIC ANALGESICS	**Ultracet** (tramadol/APAP) **Ultram** (tramadol) **Rybix ODT** (tramadol)
COX-II INHIBITORS	**Celebrex** (celecoxib)

SaveonSP

SaveonSP is a program covering certain specialty medications and ensures that, once you are enrolled and eligibility is confirmed, you have no financial responsibility for those medications. Your specialty medication will be filled through Accredo. The 150+ medications included in the SaveonSP program consist of products covering conditions such as Hepatitis C (Hep C), Multiple Sclerosis (MS), Psoriasis, Inflammatory Bowel Disease (IBD), Rheumatoid Arthritis (RA), Oncology, and others. You can access the list of medications included in the program at **www.saveonsp.com/nyccbf**. If you are using a medication included in the program, you may be eligible.

Who is Eligible for SaveonSP?

- Individuals who are currently taking a medication on the SaveonSP Specialty Drug list, and
- Individuals who use their coverage under this Fund as their primary health coverage.

***Individuals who use Medicare as their primary insurance are not eligible for this program.**

What do I need to do to enroll?

- Review the list of medications included in the program. If you are taking one or more of the medications, call SaveonSP to enroll at 800-683-1074.
- If you are already enrolled in a manufacturer program, be sure to have your manufacturer program issued ID available when you call; the call will be very short. If you are new to the program, the call will take approximately 10 minutes.
- If you do not enroll prior to submitting a prescription to Accredo for filling, a SaveonSP Patient Service Representative will contact you via phone prior to dispensing. They will assist you with enrollment if your medication is part of the program.

- Certain manufacturers require annual enrollment. You will only be contacted once a year to ensure you are properly enrolled in this program.

Step Therapy

Certain drug categories will require a generic drug be tried first before a brand drug may be covered. In some cases, brand drugs can be approved through a prior authorization process. This both saves you money as well as delivers an appropriate first line therapy.

Some examples of Step therapy the Fund utilizes are:

- Oxycontin,
- Blood Pressure medications in the "ARB" class, and
- Some topical creams and acne products.

Example of how a Step therapy works: OxyContin ER will require alternative Step therapies on long-acting generic medications, such as Morphine ER, Oxymorphone ER, Fentanyl patches, etc., before use. Exceptions are made for cancer patients.

If you fill or refill a prescription for one of these medications without pre- approval, you will have to pay the full cost of the medication instead of just a Copayment.

If you're taking one of these medications and don't want to pay the full cost, here are some options:

- Ask your doctor to consider changing your prescription to one that doesn't require a review;
- Your lowest-cost option may be a 90-day prescription from the Express Scripts Pharmacy®. The Express Scripts Pharmacy will mail your prescription to you, and standard shipping is free; and
- If your doctor believes there are special reasons you should continue your current medication, he/she can request a coverage review by calling 800-417-1764, 8:00 a.m. to 9:00 p.m., ET.

Coverage Limitations

For most prescription drugs, the Fund provides coverage in quantities up to a 30-day supply at retail pharmacies and up to a 90-day supply through the mail-order pharmacy. However, coverage for certain prescription drug categories will have quantity limits and be subject to specific coverage requirements. These limits are based upon FDA-approved prescribing and safety information, clinical guidelines and uses considered reasonable, safe and effective.
If you fill a prescription that exceeds the quantity limit, you will be responsible for the cost of the additional medicine. If special circumstances exist, your physician may request a review for additional coverage.

The following is a list of drugs that currently have quantity limitations or coverage requirements. Generic forms of the prescription medications listed are also subject to the same quantity limitations and coverage requirements. The list of drugs with quantity limitations or coverage requirements is subject to change. Contact Express Scripts at 800-753-2851 for up-to-date information.

Examples of Prescription Drugs with Quantity Limitations and/or Coverage Requirements:		
Drug Category	**Drug Name**	**Quantity Limitation or Coverage Requirement**
ERECTILE DYSFUNCTION	**Caverject** (alprostadil) **Cialis** (tadalafil) **Edex** (alprostadil) **Levitra**, **Staxyn** (vardenafil) **MUSE** (alprostadil) **Viagra** (sildenafil citrate)	Quantity Limitation
HYPNOTICS	**Ambien, Ambien CR** (zolpidem) **Edluar** (zolpidem) **Intermezzo** (zolpidem) **Lunesta** (eszopiclone) **Rozerem** (ramelteon) **Silenor** (doxepin) **Sonata** (zaleplon) **Zolpimist** (zolpidem)	Quantity Limitation
MIGRAINE THERAPY	**Amerge** (naratriptan) **Axert** (almotriptan) **Frova** (frovatriptan) **Imitrex, Imitrex SR, Imitrex Injectable** (sumatriptan) **Maxalt, Maxalt MLT** (rizatriptan) **Migranal NS** (dihydroergotamine) **Relpax** (eletriptan) **Sumavel** (sumatriptan) **Treximet** (sumatriptan/naproxen) **Zomig** (zolmitriptan)	Quantity Limitation
NARCOTIC ANALGESICS	**Abstral** (fentanyl) **Actiq** (fentanyl) **Fentora** (fentanyl) **Lazanda** (fentanyl) **Onsolis** (fentanyl) **Duragesic** (fentanyl) **Oxycontin** (Oxycodone) Combination Narcotics Oxymorphone Hyrdromorphone	Quantity Limitation
NON-NARCOTIC ANALGESICS	**Conzip ER** (tramadol) **Ryzolt** (tramadol) **Ultram ER** (tramadol)	Quantity Limitation

Expenses Not Covered

Prescription drug benefits are not paid for:

- Drugs and/or medications:
    - Obtained after the date your coverage ends,
    - Filled for more than a 30-day supply at a retail pharmacy or a 90-day supply through mail order,
    - That are experimental and/or investigational, which means they are not FDA-approved and are not legally available for distribution,
    - For which your cost is equal to or less than the Copayment,
    - Received while confined in a Hospital (however, these costs may be covered by the Fund's Hospital and Medical Benefits through Empire),
    - Dispensed for a purpose other than the treatments recommended by the FDA,
    - Prescribed as a result of an Injury or Illness covered by Workers' Compensation, or
    - Intended as nutritional or diet supplements;
- Refills exceeding the number your physician prescribes;
- Refills more than one year after the date of the original prescription;
- Non-legend (over-the-counter) drugs or medications, except for aspirin, and other Provider-required preventive medications;
- Immunization agents, vaccines, biological sera, blood or blood plasma (however, these may be covered by the Fund's medical benefits);
- Fertility medications;
- Growth hormones, except when Medically Necessary and pre-authorized;
- Alcohol wipes;
- Retin-A, except when Medically Necessary;
- Vitamins available without a doctor's prescription;
- Syringes for dispensing prescribed medication (these are covered by the Fund as medical supplies);
- Select Compounded Medications when there is no proven use or for drugs that have alternative commercially available products;
- Zohydro ER;
- Lovaza; and
- Vascepa.

Clinical Intervention

Express Scripts provides a clinical intervention process to help guard against drug interaction problems that can occur, for example, when different medications are prescribed by more than one physician or specialist. A registered pharmacist will discuss alternative medications with your doctor and notify you of any change in your prescribed medication. However, your doctor makes the final decision on all of your prescribed medications. A clinical intervention pharmacist may also (1) suggest changing to a preferred drug or (2) call your doctor if the prescription instructions are different from the drug manufacturer's instructions.

Fraud, Waste, and Abuse Program

The Welfare Fund participates in a Fraud, Waste, and Abuse ("FWA") program that is offered through Express Scripts. The FWA program is an investigative service program that helps detect potential fraud, control prescription drug costs, and maximize participant health. Here's how it works:

- The program identifies prescribers and participants with unusual or excessive utilization patterns.
- If unusual or excessive behavior is substantiated through a case review, participants can be restricted to one pharmacy and/or one physician for controlled substances and muscle relaxants. The decision to impose restrictions is made when participants are having prescriptions for a particular controlled substance or muscle relaxant filled at more than one pharmacy and/or issued by more than one physician. With controlled substances and muscle relaxants, there is a significant risk of an adverse reaction due to a duplicate prescription or a drug-to-drug interaction. Eliminating the possibility of having multiple physicians write prescriptions and having prescriptions filled at multiple pharmacies promotes participant health.
- If, based on your prescription utilization patterns, Express Scripts assigns you to only one pharmacy, and/or one physician, you will be notified in writing by Express Scripts of those restrictions and their effective date.
- If you have a prescription filled at a pharmacy and/or by a physician other than the one assigned to you after written notification of your restrictions, the Welfare Fund will not provide any reimbursement for that prescription and you will be responsible for the full cost of the drug.

If you are notified in writing by Express Scripts that you are being restricted to one pharmacy and/or one physician for a particular controlled substance or muscle relaxant, you may either appeal the decision, or request to change the pharmacy and/or physician you are being restricted to utilizing. Your appeal or request for pharmacy/physician changes should be submitted in writing to:

Express Scripts
Drug Utilization Review Program
One Express Way
St. Louis, MO 63123
Mailstop 3W03

If you have a prescription filled from a provider or pharmacy that is not your assigned provider or pharmacy, no coverage will be provided and you will be responsible for the full cost of the prescription.

PRESCRIPTION DRUG BENEFITS FOR MEDICARE-ELIGIBLE RETIREES AND MEDICARE-ELIGIBLE DEPENDENTS

Prescription drug coverage for Medicare-eligible Retirees and their Medicare-Eligible dependents are provided through a Medicare Part D plan (known as an "EGWP"). Coverage under this plan is described in a separate document which can be obtained by calling Express Scripts at 800-311-2757 or visiting Express Scripts' website at **www.express-scripts.com**.

DENTAL BENEFITS

Limitations on Benefits

The following sections describe the Fund's Dental Benefits for Active, Pre-Medicare and Medicare Retirees. Starting on page 139, the ***Claims and Appeals Procedures; Appeals for Dental Benefits; Other Information You Should Know;*** *and* ***Your Rights Under the Employee Retirement Income Security Act of 1974*** sections describe how you can appeal a denial of benefits. If you or your Beneficiary take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Plan Works

Dental benefits are administered by Self-Insured Dental Services, Inc. ("ASO/SIDS"). You have the option of going to any dentist or selecting from a panel of "participating dentists." However, whether you go to a participating or a non-participating dentist, all benefits are paid according to a "schedule of allowances" that provides a set fee for a particular procedure.

Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act ("HIPAA") and the ACA as they are provided under a separate contract. You may decline Dental benefits. Contact the Fund Office if you wish to decline Dental benefits.

When you use a participating dentist, your out-of-pocket expense for covered services, subject to Plan maximums and frequency limitations, is limited to the amount applied towards your individual calendar year deductible. Many diagnostic and preventive services that are not subject to the deductible are covered in full. See the "**Schedule of Covered Dental Allowances**" section for more information.

This coverage is designed to encourage regular checkups and preventive care and to correct minor dental problems before they become serious. Benefits are provided for diagnostic and preventive services, basic restorative services, major restorative services, bridges and dentures, periodontal treatment, oral surgical procedures, and orthodontic services. Basic and major dental services are subject to a ***$100 annual deductible***, and all dental services are subject to ***a maximum Fund payment of $2,500 per ACTIVE individual /$1,500 per RETIREE individual per calendar year*** except for certain pediatric dental services. You and your dependent Children are covered for orthodontic treatment up to a maximum of 24 months of treatment.

Retirees residing abroad. The Plan **does not** provide dental coverage for Retirees residing outside the United States.

The following chart summarizes the procedures and costs covered.

OVERVIEW OF DENTAL COVERAGE
ANNUAL DEDUCTIBLE: $100 per covered individual per calendar year, applies to basic and major services. Deductible applies when using a PPO or Non-PPO provider
ANNUAL MAXIMUM: ACTIVE: $2,500 per covered individual per calendar year
RETIREE: $1,500 per covered individual per calendar year

Procedures Covered
DIAGNOSTIC and PREVENTIVE SERVICES—routine procedures, such as oral examinations, bitewing X-rays and adult/child prophylaxis (cleaning).
BASIC SERVICES—commonly used procedures, such as amalgam fillings, simple extractions and root canals.
MAJOR SERVICES—surgical extractions, periodontal treatment, gum surgery, crowns, inlays, fixed bridgework, removable dentures, and repairs to bridgework and dentures.
ORTHODONTIC SERVICES—correction of a handicapping malocclusion, including an initial examination insertion of appliance and monthly treatment visits.

Network of Participating Dentists

The Welfare Fund has contracted with ASO/SIDS to manage its own network of participating ("in-network") dentists. You choose the participating dentist that best suits your needs. All participating dentists in the ASO/SIDS network have agreed to accept the Welfare Fund's Schedule of Covered Dental Allowances. That means that your dental benefit coverage will be the same no matter which participating dentist you choose.

The dental benefit administrator is:

Administrative Services Only, Inc./
Self-Insured Dental Services ("ASO/SIDS")
P.O. Box 9005 Group 95
Lynbrook, NY 11563
Telephone: (800) 537-1238
Website: **http://www.asonet.com**

You save money when you use dentists who are participating in the ASO/SIDS network. These dentists have agreed to accept the benefits provided under the Fund's Schedule of Covered Dental Allowances as payment in full (subject to any applicable deductibles). For information about participating providers in your area, contact ASO/SIDS at (800) 537-1238.

When you use a participating dentist, subject to Plan maximums and frequency limitations:

- Diagnostic and preventive dental services are covered in full in accordance with the Plan's schedule of maximum allowances; and
- Once you meet the deductible, basic and major restorative services are covered in full up to the Plan's maximum allowance.

If You Are Treated by a Non-Participating Dentist

If you are treated by a non-participating dentist, you or your dentist will be reimbursed according to the Fund's Schedule of Covered Dental Allowances. The charges of non-participating dentists are generally higher than the Plan's scheduled allowances, and you are responsible for any difference between the amount a non-participating dentist charges and the amount the Fund will pay for covered services.

Pre-Treatment Estimate

This process informs you and your dentist, in advance of treatment and before any expenses are incurred, what benefits are provided by the Plan.

It is recommended that a pre-treatment estimate be filed by your dentist if your dental care is going to cost more than $500 in a 90-day period or includes crowns, bridges, dentures, orthodontics, inlays, or periodontal surgery.

Don't forget - Whether you go to a participating or a non-participating dentist, the Plan only pays up to the amount shown on the Schedule of Covered Dental Allowances.

To obtain a pre-treatment estimate, ask your dentist to describe the treatment plan and expected charges on a claim form. X-ray charges should be included in a pre-treatment estimate for any proposed treatment involving root canal therapy, inlays, crowns, bridges, dentures, and periodontal surgery. Submit the completed claim form to:

Self-Insured Dental Services, Inc. ("ASO/SIDS")
P.O. Box 9005 Group 95
Lynbrook, NY 11563

ASO/SIDS will review the proposed treatment and will provide you and your dentist with an explanation of benefits form. This form will indicate the benefit amount for each covered procedure and identify services that are not covered or not payable by the Fund.

The pre-treatment estimate will remain valid for one year, even if some or all of the work is done by another dentist, provided that you are still eligible for Fund benefits when any of the approved services are rendered, and that there has been no significant change in your dental condition since the estimate was issued. Payment will be made in accordance with the applicable Plan allowances and limitations in effect at the time the covered services are completed.

Orthodontic Services

A dentist must diagnose the need for orthodontic services and must indicate that the orthodontic condition consists of a handicapping, abnormal, correctable malocclusion. Before treatment begins, ASO/SIDS should estimate the applicable Plan allowance for orthodontic services under the pre-treatment estimate program.

Orthodontic services and their applicable benefit are described on the following chart.

Orthodontic Service	Benefit
Diagnosis and insertion of orthodontic appliances	$450
Active treatment, up to a maximum of 24 months	$50 per month
Retention treatment following active treatment, up to a maximum of 18 months	$100 per every six months

These orthodontic benefits are not subject to the annual deductible, nor do they count towards your annual maximum, but they are subject to the orthodontia lifetime maximum of 24 months of treatment.

Extension of Dental Benefits

If your or your dependent's eligibility terminates in the course of certain dental treatment, the patient's dental coverage will be extended for up to 90 days after eligibility would otherwise end so that the work can be completed. This limited extension applies to the following procedures only:

- Crowns, fixed bridgework and full or partial dentures—extension applies if impressions were taken and/or teeth were prepared while the patient was eligible;
- Orthodontic appliances and active treatment—extension applies if impressions were taken while the patient was eligible; or
- Root canal therapy—extension applies if the pulp chamber was opened while the patient was eligible.

There is no extension for any dental service other than those noted above.

Schedule of Covered Dental Allowances

The chart below lists all of the dental services covered by the Plan and the maximum benefit amount the Plan will pay for each service. **Remember:** participating providers have agreed to accept the Plan's schedule of benefits as payment in full, subject to the applicable $100 annual deductible per covered individual per calendar year.

DIAGNOSTIC & PREVENTIVE	PLAN PAYS
ORAL EXAMINATION Maximum-two per calendar year	$15
FULL MOUTH SERIES X-RAYS 10 to 14 periapical/bitewing films	$30
PANORAMIC FILM	$30
PERIAPICAL OR BITEWING, per film	$4
OCCLUSAL FILM	$13
CEPHALOMETRIC FILM	$34
POSTERIOR-ANTERIOR FILM	$32
LATERAL FILM	$32
TEMPOROMANDIBULAR FILM X-ray maximum-$50 per calendar year	$40
PROPHYLAXIS Including scaling and polishing; maximum two per calendar year	
Adult	$28
Child, to age 15	$25
FLUORIDE TREATMENT Excluding prophylaxis to age 15, two per calendar year	$18
SEALANT Unrestored permanent posterior teeth only, to age 15. Lifetime maximum - $45 per quadrant	$15
SPACE MAINTAINER	
Removable	$98
Fixed	$135
BASIC RESTORATIVE	
AMALGAM FILLINGS	
One surface	$35
Two surfaces	$45
Three surfaces	$55
Four or more surfaces	$65
COMPOSITE RESIN-ANTERIOR	
One surface	$35
Two surfaces	$45
Three surfaces	$60
Four or more and incisal angle	$60
COMPOSITE RESIN-POSTERIOR	
One surface	$40
Two surfaces	$50
Three surfaces	$60
MAJOR RESTORATIVE Pre-operative periapical X-ray required. There is a five-year frequency limitation on replacements.	
CROWNS-RESIN	$120

DIAGNOSTIC & PREVENTIVE	PLAN PAYS
Resin with metal	$325
Porcelain	$325
Porcelain with metal	$375
Full cast with metal	$350
METALLIC INLAY	
One surface	$200
Two surfaces	$250
Three surfaces	$300
PORCELAIN INLAY	
One surface	$200
Two surfaces	$250
Three surfaces	$300
STAINLESS STEEL CROWN (Primary tooth)	$100
CAST POST & CORE	$100
PREFAB POST and CORE	$86
ENDODONTICS X-ray evidence of satisfactory completion required.	
PULPOTOMY	$75
ROOT THERAPY	
Anterior	$200
Bicuspid	$250
Molar	$325
APICOECTOMY	$130
APICOECTOMY Maximum per tooth	$260
RETROGRADE FILLING	$60
PROSTHODONTICS Preoperative X-rays are required when filing a claim for pre-treatment review or payment on all prosthetics. X-rays of the full arch must be included for all bridgework. There is a five-year frequency limitation from date of installation on all prosthetics.	
COMPLETE DENTURE Immediate or permanent	$400
PARTIAL DENTURE – UNILATERAL	$340
PARTIAL DENTURE – BILATERAL Acrylic base with clasps and rests	$325
Cast metal base	$400
PRECISION ATTACHMENT	$100
BRIDGE PONTIC Full cast	$300
Resin with metal	$300
Porcelain with metal	$375
ABUTMENT – INLAY TWO SURFACES	$250
ABUTMENT – INLAY THREE SURFACES	$300
CAST METAL RETAINER-ACID ETCH BRIDGE	$200
BRIDGE ABUTMENT Crown-resin with metal	$325
Crown-porcelain fused to metal	$375
Crown-full cast	$300
Crown repair	$100
DENTURE RELINE COMPLETE or PARTIAL – CHAIRSIDE	$80

DIAGNOSTIC & PREVENTIVE	PLAN PAYS
DENTURE RELINE-PARTIAL – LABORATORY	$100
DENTURE RELINE-COMPLETE – LABORATORY	$125
DENTURE REPAIRS	
Denture adjustment	$25
Repair cast framework	$95
Repair resin denture base	$70
Replace tooth in denture	$65
Add tooth to existing partial denture	$65
RECEMENT CROWN OR INLAY	$25
RECEMENT BRIDGE	$30
BRIDGE REPAIR BY REPORT	$100

	Plan Allowance	Co-Pay
Endosteal Implant	$1,200	$0
Subperiosteal Implant	$1,200	$0
Transosseous Implant	$1,200	$0
Prefabricated Abutment	$200	$275
Custom Abutment	$200	$275
Abutment Supported Porcelain Ceramic Crown	$375	$300
Abutment Supported Porcelain/Metal Crown	$375	$300
Abutment Supported Crown	$375	$300
Abutment Supported Cast High Noble Metal Crown	$375	$300
Abutment Supported Noble Metal Crown	$375	$225
Implant Supported Porcelain Ceramic Crown	$375	$600
Implant Supported Porcelain/High Noble Metal Crown	$375	$600
Implant Supported High Noble Metal Crown	$375	$600

PERIODONTIC SERVICES Although eight teeth constitute the anatomic complement of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.	
SCALING and ROOT PLANING, INCLUDING PROPHYLAXIS Per quadrant; maximum allowance on any combination of the following services is $200 in a calendar year	$50
Two or more quadrants per visit	$75
Periodontal maintenance	$60
FULL MOUTH DEBRIDEMENT	$75
PERIODONTAL SURGERY Confirmation by charting and/or X-rays required per quadrant of at least 5 teeth	
Localized delivery of chemotherapeutic agent maximum allowance $150 per quadrant	$50
Gingivectomy, gingivoplasty and mucogingival surgery per quadrant	$150
Osseous surgery, including gingivectomy-per quad osseous graft, per quadrant	$375 $75
PEDICLE or FREE SOFT TISSUE GRAFTS	$200
ORAL SURGERY	
ROUTINE EXTRACTION	$40

DIAGNOSTIC & PREVENTIVE	PLAN PAYS
SURGICAL EXTRACTION Must be demonstrated by x-ray	
Erupted tooth	$65
Removal of residual roots	$90
Impaction-soft tissue	$100
Impaction-partial bony	$175
Impaction-complete bony	$200
ALVEOLOPLASTY – PER QUAD	$125
BIOPSY OF ORAL TISSUE – HARD TISSUE	$100
SURG.EXP-IMP/UNERUP(FOR ORTHO)	$175
SURG.EXP-IMP/UNERUP(AID ERUPT)	$125
REMOVAL OF CYST OR TUMOR- <1.25	$75
REMOVAL OF CYST OR TUMOR- >1.25	$100
FRENULECTOMY	$95
ORTHODONTICS	
INITIAL FIXED APPLIANCE	$450
ACTIVE TREATMENT – PER MONTH Maximum of 24 months	$50
POST-TREATMENT STABILIZATION DEVICE	$110
PASSIVE TREATMENT – PER 6 MONTHS Maximum of 18 months	$100
MINOR TOOTH MOVEMENT	
Removable appliance	$225
Fixed appliance	$225
ADJUNCTIVE SERVICES	
PALLIATIVE TREATMENT No other treatment than visit	$30
GENERAL ANESTHESIA-per 15 minutes Plan pays first 30 minutes only	$55
OCCLUSAL GUARD	$225
SPECIALIST CONSULTATION Includes examination	$50
BEHAVIOR MANAGEMENT Only when rendered by a participating pedodontist in conjunction with other treatment only	$50
TOOTH WHITENING – PER ARCH Must be provided by a licensed dentist using materials and equipment specifically designed to accomplish tooth whitening in a one-visit chairside setting on natural unrestored teeth. All other teeth-whitening products or take-home method, including those provided by a dentist, are not covered. Lifetime maximum – one treatment per arch	$150

How to File a Claim

Participating Dentist. If you receive covered services from a participating provider, you do not have to pay the dentist any money for covered services other than the deductible, if applicable, and you do not have to file a claim. The dentist's office will file the claim form. You are expected to assign benefits on the claim form so that the participating dentist can be paid directly by ASO/SIDS.

Non-Participating Dentist. When your dentist is not a participating provider, you or your dentist should file a claim form with ASO/SIDS. Claim forms are available from ASO/SIDS or the Fund Office. When you use a non-participating dentist, you are responsible for the difference between your dentist's charges and the maximum benefit amount listed in the Plan's Schedule of Covered Dental Allowances.

Completed forms, whether the services are provided by a participating or a non-participating dentist, should be sent to:

Administrative Services Only, Inc.
Self-Insured Dental Services ("ASO/SIDS")
P.O. Box 9005 Group 95
Lynbrook, NY 11563

See the section called "Claims and Appeals Procedures" for additional information on filing claims and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Exclusions and Limitations

There is no coverage for:

- Any charges that exceed the amounts shown in the Schedule of Covered Dental Allowances;
- Treatment for the purpose of cosmetic improvement;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown, inlay or denture within five years after the date it was originally installed;
- Any replacement of a bridge, crown, inlay or denture which can be made usable according to accepted dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to:
    - Change vertical dimension;
    - Diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
- Stabilize periodontally involved teeth;
- Periodontal splinting;
- Multiple bridge abutments;
- Over-the-counter analgesia;
- Services that do not meet accepted dental standards;
- Services not specifically included in the Schedule of Covered Dental Allowances;
- Services or supplies resulting from an accidental Injury, which are deemed to be the responsibility of a third party;
- Any care that is covered under Workers' Compensation or a similar law, or for an Injury arising out of, or in the course of, any employment for wage or profit;
- Charges made by a Veterans Administration ("VA") facility for a service-related Illness or Injury;
- Services for which payment is unlawful where the person resides when the expenses are incurred;
- Services for which there would be no charge in the absence of this coverage, including services provided by a member of the patient's immediate family;
- Charges for unnecessary care, treatment or surgery;

- Any charges that are paid for by a government program; and
- Experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Important Definitions

Dentist – A person who is licensed to practice dentistry in the state where the service is provided.

Necessary treatment – A procedure, service or supply that is required or appropriate for the treatment of your dental condition according to generally accepted standards of care.

Non-participating dentist – A dentist who does not have an agreement with ASO/SIDS to accept the Fund's maximum allowance as payment in full for covered services.

VISION BENEFITS

Limitations on Benefits

The following sections describe the Fund's Vision Benefits for Actives and Pre-Medicare and Medicare-Eligible Retirees. Starting on page 139, the ***Claims and Appeals Procedures; Appeals for Vision Benefits; Other Information You Should Know;*** *and* ***Your Rights Under the Employee Retirement Income Security Act of 1974*** sections describe how to appeal a denial of benefits. If you or your Beneficiary take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Vision Benefit Works

Vision benefits are provided through two networks of Providers—Comprehensive Professional Systems ("CPS"), (212) 675-5745, and General Vision Services ("GVS"), (800) 847-4661. You may use either network, or you may use a non-network Provider. Selections of frames and lenses may vary among the two networks and, in some instances, among locations in the same network.

Vision benefits are treated as a stand-alone (or excepted) benefit under HIPAA and the ACA. You may decline Vision benefits. Contact the Fund Office if you wish to decline Vision benefits.

Benefits

You and your covered dependents are each entitled to an eye examination and new glasses or contact lenses once every year (i.e., every 365 days). If you visit a Participating Provider, there are no out-of-pocket costs if the frames and lenses you select are part of the program. If the frames and lenses you select are outside the program, you will receive a credit towards your purchase. Additionally, if you use a Participating Provider, you may purchase safety glasses in lieu of normal eyeglasses, subject to the applicable rules (one eye exam/glasses once every 365 days).

Individuals residing abroad. The Fund **does not** provide vision coverage for individuals residing outside the United States.

Covered Services

The Fund will pay a Participating Provider a total of $125. Up to $25 is reimbursed for an eye exam, with the balance available for a pair of frames and/or lenses. If you visit a Non-Participating Provider, the Fund will reimburse you up to $125 for the same package of services. To obtain a list of Participating Providers, contact CPS or GVS.

Vision Costs

Some services from Participating Providers require that you pay a portion of the cost, as listed below. If you receive any of these services from a Non-Network Provider, you will be responsible for any cost above your $125 allowance.

Service Type	Your Cost at CPS	Your Cost at GVS
Scratch-resistant coating, single vision	$10	$10
Scratch-resistant coating, bifocal or trifocal	$15	$15
High-index single vision plastic lenses	$50	No charge
High-index bifocal plastic lenses	$70	No charge
Polycarbonate single vision lenses	$30	$70
Polycarbonate bifocal lenses	$70	$100
Reflection-free coating	$40	$40
Transition single vision lenses	$75	$75
Transition bifocal/multifocal lenses	$100	$100
Hyper-index	$125	$125

How to File a Claim

Network Provider. Simply provide your name and Social Security Number or UBC number to the Network Provider. The Provider will submit the claim form to the Fund Office for payment. If you receive any of the services described under "Costs" (shown above), you will also be required to pay your share of the cost.

Non-Network Provider. When you visit a Provider who is not participating in the CPS or GVS network, you must pay the full fee and submit an itemized receipt/invoice to the Fund Office for reimbursement. The Fund will reimburse you up to the amount it would have paid if you had visited a Participating Provider (up to $125 for an eye examination and a pair of frames and/or lenses).

Reserve Trigger Point

In order to timely respond to any deterioration in the Fund's financial condition, vision and dental benefits are subject to a "Reserve Trigger Point." Pursuant to the Reserve Trigger Point, if the assets of the Fund drop below a certain level, vision and dental benefits will be terminated and subject to reinstatement when the assets return to another predetermined level. Specifically, if reserves drop below seven months, vision and dental benefits will be terminated on the first day of the next month. However, if reserves subsequently increase to nine months, vision and dental benefits will be reinstated on the first day of the following month.

HEARING BENEFITS

Limitations on Benefits

The following sections describe the Fund's Hearing benefits for Actives and Pre-Medicare and Medicare-Eligible Retirees. Starting on page 139, the ***Claims and Appeals Procedures; Appeals for Hearing Benefits; Other Information You Should Know;*** *and* ***Your Rights Under the Employee Retirement Income Security Act of 1974*** sections describe how you can appeal a denial of benefits. If you or your Beneficiary take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

Covered Services

You and your covered dependents are eligible for a hearing benefit once every four years. Although you may receive benefits from any hearing Provider, you receive the highest level of coverage when you use the network of Participating Providers affiliated with Comprehensive Professional Systems ("CPS") or General Hearing Services ("GHS").

You may obtain benefits at any Provider with whom GHS and CPS have negotiated discounts on your behalf. For a listing of Participating Providers, call GHS at (800) 847-4661 or CPS at (212) 675-5745.

Coverage is provided at no cost to you from a CPS Provider and for a $150 Copayment at a GHS Provider for the following:

- A hearing evaluation;
- Behind the ear, all-in-the canal, completely-in-the-canal and digital, programming hearing aids;
- A battery for your hearing aid, with a one-year guarantee;
- CPS only: the ear impression (ear mold) is also covered; and
- Unlimited services with respect to your hearing aid for one year.

If you select a hearing aid that is not part of the Fund package, you may have additional out-of-pocket costs which are not eligible for reimbursement under the Plan.

When you visit a Non-Network Provider, you must pay for the services you receive and you must submit a claim to the Fund Office. The Fund will reimburse you the same benefit amount it would have paid if you had visited a Network Provider (maximum benefit of $350 for each ear, once every four years). This hearing benefit is available to all eligible family members.

How to File a Claim

Network Provider. Simply provide your name and Social Security number to the Network Provider. The Provider will submit the claim form to the Fund Office for payment.

Non-Network Provider. When you visit a Provider that is not in the CPS or GHS networks, you must pay the full fee and submit an itemized receipt to the Fund Office for reimbursement. Be sure to keep a copy of the itemized receipt for your records.

The ***Claims and Appeals Procedures*** section has additional information on filing claims and the procedures to follow in appealing a claim that is wholly or partially denied.

MEDICAL/HOSPITAL BENEFITS FOR MEDICARE-ELIGIBLE RETIREES AND DEPENDENTS

The Welfare Fund's health care coverage for Medicare-eligible retirees and dependents through a Medicare Advantage plan are administered by UnitedHealthcare® ("UHC"). The plan is called the UnitedHealthcare® Group Medicare Advantage ("PPO") Plan (the "UHC Plan").

Medicare-eligible retirees receive their prescription drug benefits through Express Scripts (see page 104 for more information).

This section provides a high-level overview of the benefits for Medicare-eligible retirees and dependents. UHC will send you materials upon enrollment with detailed information.

Medicare Enrollment Responsibilities and Retiree Welfare Coverage

Important Reminder: The Centers for Medicare & Medicaid Services ("CMS") have strict eligibility and enrollment rules which you and your Medicare-eligible dependent(s) must follow in order to enroll in the UHC Plan. If you and your eligible dependent(s) have not first enrolled in Medicare Parts A and B and paid he premiums for Medicare Part B coverage, you may not enroll in the UHC Plan. Further, you and/or your Medicare-eligible dependent(s) will be disenrolled from the UHC Plan, and be returned to Original Medicare, if either join an individual Prescription Drug Plan. CMS requires that a Retiree or Medicare-eligible dependent must be fully enrolled with the Welfare Fund in order to have coverage under the UHC Plan. Neither the Welfare Fund nor UHC has any discretion concerning CMS's eligibility requirements.

To reiterate, if you and/or your covered dependent(s) are (or become) eligible for Medicare, and you have Retiree coverage under the Fund or you are about to transition from Active coverage to Retiree coverage, you **MUST** enroll in both **Medicare Part A** and **Medicare Part B** in order to have any Retiree coverage. You should enroll in Medicare as soon as Medicare coverage becomes available if you want to maintain your Retiree coverage. If you do not enroll in both Medicare Part A and Part B, you will not be covered through UHC or Empire**, resulting in higher out-of-pocket costs and/or loss of coverage for you.** This includes those who retired before age 65 on a Regular Pension and later become eligible for Social Security prior to age 65. For more information regarding Medicare Enrollment, read the Frequently Asked Questions ("FAQ") document on our website at **www.nyccbf.com/wp-content/uploads/2020/09/Medicare-Eligible-Retirees-FAQ_Final_9-9-20.pdf**. You may also refer to UHC's Evidence of Coverage document, which UHC will mail to you.

Plan Overview

The UHC Plan is a Medicare Advantage plan that delivers all the benefits of Medicare Parts A and B and offers additional benefits and features. It is not a supplement plan and does not pay secondary to Medicare. All claims are submitted directly to UHC for payment, not Medicare, and UHC then pays the doctors and hospitals for your care. Other plan highlights include:

- Out-of-pocket spending is limited to the Medicare Part A deductible and the Medicare Part B deductible (note that these deductibles change almost every year; visit **www.medicare.gov** or

contact UHC for the current deductible amounts). After you meet your deductibles, the Plan pays 100% of your costs for the rest of the year.

- HouseCalls® – Once a year, a UHC health care practitioner will visit you to review your health history and medication(s), perform a physical exam, identify your health risks and provide educational information.
- NurseLine® – UHC registered nurses are available to answer your call 24 hours a day.
- Renew Rewards – You can get rewarded for completing screenings and preventive care such as having your annual wellness visit.
- SilverSneakers® - Get access to exercise equipment, classes, and more at 14,000+ fitness locations.
- Solutions for Caregivers - Support for you when you're caring for a loved one.

How the UHC Plan Works

Under the UHC Plan, you can use any doctor or hospital in the U.S. that participates in Medicare and accepts the UHC Plan. You have the same benefits whether you use in-network or out-of-network providers, i.e., there is no additional cost share when using an out-of-network provider. Any excess charges (balance billing) are paid by the UHC Plan, not by you.

Each Medicare-Eligible retiree and Medicare-Eligible dependent will be covered separately. The family coverage option does not exist under Medicare or Medicare Advantage Plans. Each Medicare-Eligible individual has his/her own policy, and each person has his/her own individual member ID card and plan documents.

If you have some family members who are eligible for Medicare coverage and others who are not eligible for Medicare, you're considered a split family which means that there will be different coverage depending on whether the person is eligible for Medicare coverage. For those who have Medicare, coverage will be through the UHC Plan. Individuals without Medicare and currently covered through the Welfare Fund will remain on their current coverage. Changes can be made during the annual open enrollment period which runs from October through November of each year.

Important Reminder: You must be enrolled in both Medicare Part A (hospital benefit coverage) and Part B (medical benefit coverage) to be eligible for coverage under the UHC Plan. The requirement to be enrolled includes timely payment of your Medicare Part B premiums to maintain that coverage. In general, Medicare Part A provides coverage for inpatient care at a hospital, inpatient/outpatient skilled nursing facility care, hospice care and home health care. Medicare Part B offers coverage for medically necessary services and supplies such as evaluations, treatment and surgeries provided by duly licensed physicians, durable medical equipment, inpatient/outpatient mental health treatment, air and land ambulances, and diagnostic testing.

Benefit Overview

This is a short description of benefits from the UHC Plan. For complete information, please refer to the UHC Summary of Benefits or Evidence of Coverage and other UHC materials. Limitations, exclusions, and restrictions may apply. The benefits shown below are effective in 2022.

Plan Costs

	In-Network	Out-of-Network
Annual Medical Deductible	This plan has two annual deductibles for certain medical services. $203 combined medical deductible per plan year for most Part B in-network and out-of-network services. $1,484 combined medical deductible per plan year for most Part A in-network and out-of-network services. These are the 2021 amounts based on the Medicare Part A and Part B deductibles and may change for 2022.	
Annual Out-of-Pocket Maximum (The most you pay in a plan year for covered medical care)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,687. These are the 2021 amounts based on the Medicare Part A and Part B deductibles and may change for 2022.	

Medical Benefits

	In-Network	Out-of-Network
Doctor's office visit	$0 Primary care provider (PCP)	$0 Primary care provider (PCP)
	$0 Virtual doctor visits	$0 Virtual doctor visits
	$0 Specialist	$0 Specialist
Preventive services Medicare-covered	$0 copay	
Inpatient hospital care	$0 copay per stay	$0 copay per stay
Skilled nursing facility (SNF)	$0 copay per day up to 100 days	$0 copay per day up to 100 days
Outpatient surgery	$0 copay	$0 copay
Outpatient rehabilitation Physical, occupational, or speech/language therapy	$0 copay	$0 copay
Mental health outpatient and virtual	$0 Group therapy	$0 Group therapy
	$0 Individual therapy	$0 Individual therapy
	$0 Virtual visits	$0 Virtual visits

Medical Benefits

Medical Benefits Covered by the plan and Original Medicare

	In-Network	Out-of-Network
Diagnostic radiology services such as MRIs, CT scans	$0 copay	$0 copay
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay
Therapeutic radiology services such as radiation treatment for cancer	$0 copay	$0 copay
Ambulance	$0 copay	
Emergency care	$0 copay (worldwide)	
Urgently needed services	$0 copay (worldwide)	

Additional Benefits and Programs Not Covered by Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Foot care - routine	$0 copay, 6 visits per plan year*	$0 copay, 6 visits per plan year*
Over-the-counter care FirstLine Medical	$0 copay; You receive $80 each quarter to use on approved over-the-counter products as shown in the catalog or website.	
Vision - routine eye exam	$0 copay, 1 exam every 12 months*	$0 copay, 1 exam every 12 months*
Fitness program Renew Active® by UnitedHealthcare	$0 copay for a standard gym membership at participating locations	
Post-discharge meals Mom's Meals	$0 copay for 84 home-delivered meals immediately following one inpatient hospitalization or SNF stay when referred by an advocate.	
Telephonic Nurse Services	Receive access to nurse consultations and additional clinical resources at no additional cost.	

*Benefits are combined in and out-of-network

Important Note regarding Eligibility

Remember that CMS has many rules and strict guidelines governing eligibility. Be sure to follow all time frames outlined in this SPD, as well as in the Evidence of Coverage provided to you by UnitedHealthcare. Failure to do so could result in delays or changes in your coverage dates.

COORDINATION OF BENEFITS

If you or your family members may have other health care coverage, the two health coverage programs will coordinate their benefit payments so that the combined payments from the two 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 plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Which Plan Pays Benefits First?

Here is how we determine which plan has primary responsibility for paying benefits:

- If the other plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered by one plan as an Active Employee and by another plan as a laid-off employee or Retiree, the plan that covers you as an Active Employee is primary.
- If you are covered by one plan as an employee and by the other plan as a dependent, the plan that covers you as an employee is primary.
- If you are covered by this Fund and the Hollow Metal Trust Fund, this Fund is primary.

For a dependent Child covered under both parents' plans, the primary plan is:

- The plan of the parent whose birthday comes earlier in the calendar year (month and day);
- The plan that has covered the parent for a longer period of time, if the parents have the same birthday, or
- The father's plan, if the other plan does not follow the birthday rule and uses gender to determine primary responsibility.

When the parents are divorced or separated:

- If there is no court decree establishing financial responsibility for the Child's health care expenses, the plan covering the custodial parent is primary.
- If the custodial parent is remarried, his/her plan pays first, the step-parent's plan pays second and the non-custodial parent's plan pays third.
- If there is a court decree specifying which parent has financial responsibility for the Child's health care expenses, that parent's plan is primary once the Fund Office has written notice of the decree.

If none of the previous rules apply, the plan that has covered the parent longest is primary.

If the Welfare Fund is the Secondary Plan

If the Fund is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. In no case will the Fund pay more than the amount it would normally pay if it were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claims 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. Keep a copy for your records.
- You must provide information about other health care coverage you or members of your family may have whenever the Fund Office or one of its claims administrators requests it. If you fail to notify the Fund Office or its claims administrators of other group health coverage for you or your dependents that would otherwise have primary liability for claims, or if you refuse to respond to a coordination of benefits inquiry from the Fund Office or from one of its claims administrators, coverage for you and your family will be suspended.

Medicare Secondary Payer

Medicare Secondary Payer is the term generally used when the Medicare program does not have primary payment responsibility – that is, when another entity has the responsibility for paying before Medicare. Primary payers have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance coverage. Medicare is also the primary payer in certain instances, provided several conditions are met. These coordination of benefit rules are complex. If you have any questions regarding your eligibility for coverage under Medicare, you must contact the Fund Office in writing with your inquiry.

LIFE INSURANCE

The Fund provides basic and dependent Life Insurance benefits at no cost to you. This coverage is provided and insured through an insurance company (for contact information, see the chart on page 3). Please contact the Fund Office for more information about your Life Insurance benefit.

Limitations on Benefits

The following sections describe the Life Insurance Benefits available under the Fund. Starting on page 139, the *Claims and Appeals Procedures; Other Information You Should Know; and Your Rights Under the Employee Retirement Income Security Act of 1974* sections describe the actions you can take to appeal a denial of benefits. Please note that if you or your Beneficiary decides to take legal action following a denial of an appeal, the lawsuit must be filed in the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal or, if different, in the venue and within the time period established in the policy.

How the Life Insurance Benefit Works

If you die while you are an Active Employee, your Beneficiary will receive a life insurance payment equal to the sum of the highest 24 months of earnings, not counting bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation in effect during the last 30 months of Covered Employment before your death. If you worked in Covered Employment for at least 24 months, but less than 30 months, the Fund will use the highest 24 months of earnings. The minimum payment is $6,000 and the maximum payment is $25,000. (However, the amount of your Life Insurance benefit will be reduced by any accelerated death benefit paid. The accelerated death benefit is described later.)

If you are an eligible Retiree, your Beneficiary will receive a life insurance payment of $8,000, provided you pay the monthly retiree premium for Welfare benefits.

If you are an eligible Active Employee or a Pre-Medicare or Medicare-eligible **Retiree, the Fund also provides life insurance coverage for your dependents**. If your spouse or Child dies while insured under this Fund, a death benefit of $1,000 will be paid to you. In order for benefits to be paid, your dependents must be eligible as defined by the Fund at the time of death. When you die, life insurance coverage for your dependents ends at the end of the month in which you die.

Retirees Living Abroad
The Fund provides life insurance coverage to Retirees residing outside the United States. If you wish to elect Life Insurance coverage through the Fund, you must pay the full Retiree premium even if you will not utilize the other benefits offered by the Fund due to living abroad. In other words, there is no premium for only life insurance coverage.

Naming a Beneficiary

You must name a Beneficiary for your life insurance. Your Beneficiary may be one or more person(s), a trust, an estate, a charity, etc. You can also designate a contingent Beneficiary. A contingent Beneficiary receives benefits in the event the primary Beneficiary dies before you. You are automatically the Beneficiary for any life insurance coverage on your dependents.

You may change your Beneficiary at any time by submitting a new Beneficiary designation form to the Fund Office. A change in Beneficiary is not effective unless and until it is received by the Fund Office. Beneficiary designation forms are available from the Fund Office and may be downloaded from the Fund Office website. It is important to keep your Beneficiary designation up to date and you may want to review your Beneficiary designation when circumstances in your life change (e.g., marriage, divorce, birth or adoption of a Child, death). Note that a divorce does not change your Beneficiary or invalidate your prior designation of your former spouse as Beneficiary for your benefit. If you are divorced and wish to change your Beneficiary, you must submit a new Beneficiary designation form to the Fund Office.

If you do not name a Beneficiary, or if your Beneficiary dies before you, and provided the life insurance policy does not state otherwise, your life insurance benefit will be paid to:

- Your surviving spouse or, if none,
- Your Children in equal shares or, if none,
- Your parents in equal shares or, if none,
- Your brothers and sisters in equal shares or, if none,
- Your estate.

Notwithstanding the above, if the life insurance policy has different rules for payment of the benefit if you die without a Beneficiary, the Fund will apply the rules set forth in the policy.

Accelerated Death Benefit

If you're an Active Employee, you may elect to have an Accelerated Benefit of a minimum of $3,000 and a maximum of $12,500 (but the amount cannot exceed 50% of your life insurance benefits) paid to you while you are living if:

- Your life expectancy is six months or less; and
- You are insured for at least $10,000.

The accelerated death benefit is payable to you in a single lump sum, once in your lifetime. Upon your death, the life insurance benefit due to your Beneficiary will be reduced by the benefits you received under the accelerated death benefit.

To apply for an accelerated death benefit, send a written request to the Fund Office. The insurance company will require a doctor's written certification that you are terminally ill with a life expectancy of six months or less and may require an independent exam.

In the event that:

- You are required by law to accelerate benefits to meet the claims of creditors; or

- A government agency requires you to apply for benefits to qualify for a government benefit or entitlement, you will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You Become Disabled

If you are an eligible Active Employee and you become **Totally and Permanently Disabled** while covered under this Fund, you may qualify for a Disability Pension as described in the section on eligibility and participation (see page 11). If you qualify for this benefit, your life insurance coverage will be continued for as long as you remain Totally and Permanently Disabled. The amount of your life insurance coverage will be determined using the 30-month period immediately preceding the month in which you became disabled. When you reach age 65, this amount is reduced to the Retiree Life Insurance benefit amount of $8,000.

Converting to an Individual Policy

If your life insurance with the Fund ends, you may convert all or a portion of your coverage to an individual plan. You must apply for an individual policy within 31 days after your Fund coverage ends. If you have dependent life insurance, you may also convert the insurance on your spouse or Children to an individual policy. To apply for conversion coverage, contact the Fund Office.

You and your dependents may not be turned down for an individual policy when you convert your life insurance within 31 days, even if you are in poor health. Nor will you be required to have a medical examination if you apply to convert your coverage within 31 days.

How to File a Claim

You, your Beneficiary, or a family member should contact the Fund Office within 30 days of the event resulting in a covered loss to obtain a claim form. Upon receipt of the claim, the Fund Office will forward the claim to the insurer. If you die, your Beneficiary or a family member should contact the Fund Office within 30 days to obtain a claim form. A Fund Office representative will provide any necessary forms within 15 days. If the forms are not provided within 15 days, you may submit any other written proof that describes the nature and extent of your claim. In addition to completing a claim form, your Beneficiary will be asked to provide proof of your death. Generally, the Fund Office will accept an original death certificate as proof of death.

A completed claim form and proof of loss must be submitted to the Fund Office as soon as possible after a covered loss. The Fund will forward your completed documents to the insurer for processing the claim.

The *Claims and Appeals Procedures* section has additional information on filing claims and the procedures to follow in appealing a claim that is wholly or partially denied.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

(Applicable to Active Employees Only)

Limitations on Benefits

The following sections describe the Accidental Death and Dismemberment ("AD&D") Benefits available under the Fund. Starting on page 139, the ***Claims and Appeals Procedures; Other Information You Should Know;*** *and* ***Your Rights Under the Employee Retirement Income Security Act of 1974*** sections describe the actions you can take to appeal a denial of benefits. If you or your Beneficiary decides to take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal or, if different, in the venue and within the time period established in the policy.

How the Accidental Death and Dismemberment Benefit Works

The AD&D benefit is provided through a policy issued by an insurance company. This policy pays a benefit if, as the result of an accident while you are an Active Employee, you sustain a serious Injury or die within 365 days of the accident. ***There is no AD&D coverage for Retirees or covered dependents.***

In the event of your death due to a covered accident, AD&D benefits are payable in addition to those available under your Life Insurance coverage. The maximum AD&D amount that can be paid for all losses is $6,000. This amount is known as the "principal sum."

Please contact the Fund Office for more information about your AD&D benefit.

Schedule of Benefits

For Loss of:	The Benefit* is:
Life	$6,000 (Principal Sum)
Both Hands or Both Feet or Sight of Both Eyes	$6,000 (Principal Sum)
One Hand and One Foot	$3,000 (Principal Sum)
Speech, and Hearing in Both Ears	$6,000 (Principal Sum)
Either Hand or Foot and Sight of One Eye	$3,000 (Principal Sum)
Movement of Both Upper and Lower Limbs (Quadriplegia)	$6,000 (Principal Sum)
Movement of Both Lower Limbs (Paraplegia)	$6,000 (Principal Sum)
Movement of the Upper and Lower Limbs on One Side of the Body (Hemiplegia)	$3,000 (One-Half of Principal Sum)
Either Hand or Foot	$3,000 (One-Half of Principal Sum)
Sight of One Eye	$3,000 (One-Half of Principal Sum)
Movement of One Limb (Uniplegia)	$1,500 (One-Quarter of Principal Sum)
Thumb and Index Finger of Either Hand	$1,500 (One-Quarter of Principal Sum)

*If more than one loss is suffered in the same accident, payment will be made only for the loss for which the largest amount is payable.

Your Beneficiary

Generally, the Beneficiary you name for your Life Insurance is also your Beneficiary for AD&D benefits. For more information, see *Naming a Beneficiary* in the *Life Insurance* section on page 126.

Exclusions

The AD&D Benefit does not cover any loss caused or contributed to by (applicable to all benefits except Life Insurance and the Accelerated Benefit):

- Intentionally self-inflicted Injury;
- Suicide or attempted suicide, whether sane or insane;
- War or act of war; whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- Injury sustained while taking drugs, including, but not limited to, sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless as prescribed by or administered by a Physician;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while Intoxicated. Intoxicated means:
    - the blood alcohol content,
    - the results of other means of testing blood alcohol level, or
    - the results of other means of testing other substances, that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

How to File a Claim

You, your Beneficiary, or a family member should contact the Fund Office within 30 days of the event resulting in a covered loss to obtain a claim form. A Fund Office representative or the insurer will provide any necessary forms within 15 days. If the forms are not provided within 15 days, you may submit any other written proof that describes the nature and extent of your claim.

For accidental death claims, the insurance company requires, in addition to an original death certificate, evidence of the accidental nature of the death, such as a policy report, medical report, or newspaper clipping describing the accident.

For dismemberment claims, the insurance company may require that you have a medical examination that is paid for by the insurer and conducted by a doctor chosen by the insurer.

A completed claim form and proof of loss should be submitted to the Fund Office as soon as possible after any loss. The Fund will forward the completed documents to the insurer for processing.

The *Claims and Appeals Procedures* section has additional information on filing claims and procedures to appeal a claim that is wholly or partially denied.

SHORT-TERM DISABILITY BENEFITS

Limitations on Benefits

The following sections describe the Short-Term Disability Benefits available under the Fund. Starting on page 139, the ***Claims and Appeals Procedures; Other Information You Should Know;*** *and* ***Your Rights Under the Employee Retirement Income Security Act of 1974*** sections describe the actions you can take to appeal a denial of benefits. If you or your Beneficiary take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal.

How the Short-Term Disability Benefit Works

The Short-Term Disability Benefit will pay a weekly Short-Term Disability Benefit to Active Employees who become disabled and unable to work as the result of an Injury or Illness that is not work-related. Retirees who work in Covered Employment and become disabled will also be eligible for short-term disability benefits from the Fund if the Retiree is unable to work as the result of an Injury or Illness that is not work-related. There is no short-term disability coverage for dependents.

To receive disability benefits, you must be under the care of a physician who must certify to the Fund that you are disabled. Weekly benefits for pregnancy will be provided in the same manner as benefits for an "Illness."

Note: If you receive short-term disability benefits from the Fund and participate in the New York City District Council of Carpenters Pension Plan ("Pension Plan"), you should contact the Pension Plan to determine how your monthly pension benefit could be affected if you receive short-term disability benefits from the Welfare Fund.

When Coverage Begins

You are covered for Short-Term Disability Benefits whenever you are working in Covered Employment. Because you do not need to work a specified number of hours to qualify for short-term disability benefits, you may be eligible for disability benefits even when you do not qualify for Hospital and Medical or other benefits. **If your employer contributes to the Fund on your behalf pursuant to a collective bargaining agreement ("CBA") and you have elected to have such contributions reciprocated to another welfare fund pursuant to a reciprocal agreement, you are not a participant in the Fund and you shall not be eligible for Short-Term Disability Benefits from this Fund notwithstanding that contributions have been made on your behalf (since the contributions are or will be reciprocated to another welfare fund).**

When Benefits Begin

Your weekly benefit will begin on the first day of a disability resulting from an Injury or the eighth day of a disability resulting from an Illness. Benefits are payable as long as you remain disabled up to a maximum of 26 weeks of disability in any 52-week period. Under New Jersey State disability benefits

law, if your disability is due to Illness and lasts at least 21 days, your disability benefit is retroactive to the first day of disability.

"FICA" taxes will be withheld from any disability benefits due you. The FICA tax rate is currently 6.2%.

Your Benefits

In general, the Fund pays Short-Term Disability Benefits in accordance with the state laws of New York and New Jersey. If you work in New Jersey for an employer who is obligated to remit contributions to the Fund on your behalf, your employer must have an approved Private Plan with the State of New Jersey Division of Temporary Disability Insurance in order for the Fund to consider your claim for Short-Term Disability Benefits. Your benefits fall under New York or New Jersey law depending on the state in which your employer is based.

New York. Your weekly benefit is 50% of your average weekly earnings (as defined by state law) at the time you became disabled, up to a maximum benefit of $400 per week. If your disability occurs while you are actively employed or within 28 days of your last day worked, the Fund will pay you short-term disability benefits. If your disability occurs after you have been unemployed for 28 days, and you are receiving (or have filed a claim for) unemployment insurance benefits, the New York State Special Fund for Disability Benefits will pay you the Short-Term Disability Benefit. The weekly benefit paid by the New York State Special Fund for Disability Benefits is less than $400 per week.

New Jersey. Your weekly benefit as of the issuance of this SPD is 85% of your average weekly earnings at the time you became disabled up to a maximum benefit of $993 per week which is set by the State of New Jersey. The maximum may change every January 1. If your disability occurs while you are actively employed or within 14 days of your last day worked, the Fund will pay your short-term disability benefits. If your disability occurs after you have been unemployed for 14 days, and you are receiving (or have filed a claim for) unemployment insurance benefits, the New Jersey Special Fund for Disability Benefits will provide the short-term disability benefit.

"Average weekly earnings" means the amount, as established by state law, on which your Short-Term Disability Benefits are based. Generally, the eight-week period immediately preceding your disability is used to determine this amount.

How to File a Claim

Call the Fund Office at 800-529-3863 to obtain a claim form as soon as you become disabled. Return the completed form to the Fund Office along with copies of your pay stubs for the eight-week period immediately prior to your disability. Keep a copy of your claim form for your own records. The Fund retains the right to ask for evidence of continued disability at any time, or to require you to see a doctor of the Fund's choosing at the Fund's expense.

The *Claims and Appeals Procedures* section has additional information on filing claims, and procedures to follow if your claim is wholly or partially denied and you wish to appeal the decision. If you return to work and receive Short-Term Disability while actively working, you will be subject to the Fund's overpayment policy on collecting these payments.

If You Are Disabled For More Than Six Months

Remember - Short-Term disability Benefits from the Fund will end after six months. If it appears that you will be disabled for more than six months, you should contact the Fund Office. If you are disabled for more than six months, you may be eligible to continue your medical and other Fund coverage under the ***Disability Pensioner*** provision described on page 11. You should also inquire about your eligibility for Disability Pension benefits.

You should also contact the Social Security Administration to learn about any Social Security Disability benefits that you are eligible to receive.

Work-Related Disabilities

The Fund does not pay short-term disability benefits for Injuries or Illnesses arising out of or in the course of your employment. Your employer is required to carry Workers' Compensation insurance for these disabilities. However, if the Workers' Compensation carrier controverts your case and issues the appropriate form (in New York FRO1-04/SR01-04), the Fund can pay short-term disability benefits while your Workers' Compensation case is decided, subject to the limitations in this section.

SCHOLARSHIP AND RECOGNITION PROGRAM

The Fund offers a Scholarship and Recognition Program (the "Program") for unmarried dependent biological or adopted Children of eligible participants, referred to as "Qualifying Children" for purposes of the Program. International Scholarship and Tuition Services ("ISTS"), an independent and professional organization, administers the Program.

Eligibility

Your Child's eligibility for this benefit depends, first, on your eligibility. You are eligible if you meet the following eligibility requirements:

- You are working in or have worked in Covered Employment; and
- You worked at least 4,000 hours in Covered Employment in the five calendar years ending on the December 31 prior to the September for which the scholarship is awarded (and you worked at least 600 hours in each of four of those five calendar years); or
- You worked at least 6,000 hours in Covered Employment in the seven calendar years ending on the December 31 prior to the September for which the scholarship is awarded (and you worked at least 500 hours in each of five of those seven calendar years).

If you are receiving Short-Term Disability Benefits from the Welfare Fund, Workers' Compensation or state unemployment benefits, you will receive credit for seven hours worked for each day that you receive these benefits. (Proof of receipt of benefits must be submitted.)

How the Scholarship Benefit Works

This benefit is a scholarship program for unmarried, dependent Children, including biological, stepchildren (claimed on income tax) or legally adopted Children, regardless of age who:

- Are entering college as freshmen without prior college credit;
- Are entering college with prior college credit earned while completing high school (in an early admissions placement program or advanced placement program); or
- Are mid-year graduates who entered college prior to the academic year beginning in September, when a scholarship would first be payable, and who earned one-half year of college credit.

If you are a Retiree, your Qualifying Children are eligible to apply for this benefit if you met the scholarship eligibility requirements described above as of the date of your retirement.

If you are a Recovered Disability Pensioner, your Qualifying Children are eligible to apply for this benefit provided you return to Covered Employment for at least 1,000 hours, including at least 500 hours in the calendar year immediately preceding the September for which the scholarship is to be first awarded, and meet the requirements for scholarship eligibility as previously described, except that the number of calendar years in the appropriate eligibility test period may exclude those in which you were totally and permanently disabled, as defined by the Pension Fund.

Qualifying Children of deceased participants are eligible if the participant had met the scholarship eligibility requirements as previously described at the time of the participant's death. The benefit is not available for post-graduate work.

The Benefit

Charles Johnson Jr. Memorial Scholarships pays up to $3,500 for each year of a two-year or four-year academic program at an accredited college or university, or until the Child receives a bachelor's degree, whichever occurs first. The maximum amount of the award is $14,000 per student. *If a scholarship recipient completes a two-year or four-year course of study in a shorter period of time than two years or four years, as applicable, the Fund will accelerate payment of the benefit to correspond with payment of tuition and other eligible costs so that the full $7,000 or $14,000 is paid to the educational institution.

The $3,500 annual benefit should generally be used within four years from the initial award of the scholarship. However, if a recipient takes a leave of absence from the academic program for good cause, as determined in the sole discretion of the Board of Trustees, the Trustees have the discretion on an appeal to grant the remainder of a scholarship after the recipient resumes the academic program following the leave of absence. Please see page 146 for information concerning appeals to the Board of Trustees.

With the exception of New York State Regents awards, any other financial assistance (e.g., awards from other sources, including Local Unions, financial aid, loans) received by your Child must be reported to the Program which will adjust the scholarship so that the combination of financial assistance and the award do not exceed total tuition, room, board, book expenses, and usual fees. This benefit is paid directly to the educational institution, and not to you or your Qualifying Child.

If your Child is awarded a scholarship from a Local Union affiliated with the New York City District Council of Carpenters and that award is greater than the Fund's benefit, your Child will be eliminated from the Fund's competition.

How to Apply

The application process begins during the student's senior year of high school. Participant eligibility will be reviewed after all applications have been submitted and evaluated. Children of ineligible participants will be eliminated from the competition. Applications and supporting materials must be submitted online. There are no paper applications.

Your Child must register online at **https://aim.applyists.net/NYCDCC**, and follow all instructions and procedures.

Your Child must take the College Board SAT Reasoning Test by December, and upload a copy of his/her SAT scores using the drop-down menu on the academic page of the online application by December 15th. Applications received after the due date will not be accepted. Questions concerning the online application should be directed to ISTS at (855) 670-4787.

Selection Process

ISTS considers a number of factors in awarding scholarships: the student's high school academic record, SAT scores, moral character, leadership qualities, seriousness of purpose, extracurricular activities, writing samples, and letters of recommendation. The ISTS decision is final. The number of scholarships awarded is in the Trustees' sole discretion.

STATEMENT OF PRIVACY PRACTICES

Permitted Uses and Disclosures of PHI by the Fund and the Board of Trustees

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), requires that health plans, like this Plan, maintain the privacy of your personally identifiable health information (called "Protected Health Information" or "PHI"). The Welfare Fund operates in accordance with HIPAA. A complete description of your rights under HIPAA is available in the Fund's Notice of Privacy Practices ("Privacy Notice"). The following statement is a summary of the key provisions of the Fund's Privacy Notice.

The term PHI includes all individually identifiable health information related to your past, present or future physical or mental condition or payment for health care. PHI includes all information maintained by the Fund in oral, written or electronic form (sometimes referred to as "ePHI"), except for any information that is received in connection with Life Insurance or Disability benefits. While these items do not constitute PHI under HIPAA, the Fund Office generally treats them as confidential and will not disclose the information without your consent, or as required by law or as necessary in connection with claims for life insurance benefits in which case a beneficiary designation may be disclosed to an individual applying for life insurance benefits.

Neither the Plan nor the Board of Trustees will use or further disclose PHI except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Trustees. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Board of Trustees for the purpose of reviewing a benefit claim, appeal or for other reasons related to Plan administration.

The Plan's Use and Disclosure of PHI: The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as "TPO"), as defined below.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits with activities that include, but are not limited to, the following:

a. Determination of eligibility, coverage, cost-sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing self-pay amounts;

b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and
c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

Health Care Operations includes, but is not limited to:
a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;
b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR §160.103 for underwriting purposes as set forth in 45 CFR § 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
e. Business management and general administrative activities of the Plan, including, but not limited to, management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, member service, or the provision of data analyses for policyholders or the Plan sponsor.
f. Compliance with and preparation of documents required by ERISA, including Form 5500s, Summary Annual Reports and other documents.

When an Authorization Form is Needed: Generally, the Plan will require that you sign a valid authorization form (available from the Fund Office or one of the Fund's Business Associates) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for TPO or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

The Fund and the Board of Trustees are permitted to use and disclose PHI to the extent such disclosures comply with HIPAA, in very limited circumstances and when the following safeguards are in place to ensure that your privacy is protected:

- The Fund will disclose PHI to the Board of Trustees only for the Trustees' use in Plan administration functions, unless the Trustees have your written permission to use or disclose your PHI for other purposes;
- The Fund has in place safeguards to protect the confidentiality, security and integrity of your health information. PHI that is received by the Board of Trustees from the Fund will not be used or disclosed other than as permitted or required by this SPD, or as required by law, or at the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Fund;
- The Board of Trustees will not disclose your PHI to any of its Providers, agents or subcontractors unless the Providers, agents and subcontractors agree to keep your PHI confidential to the same extent as it is required of the Board of Trustees;

- The Board of Trustees will not use or disclose your PHI for any employment-related actions or decisions;
- The Fund may disclose PHI to external vendors for purposes of health care management in accordance with appropriate confidentiality agreements. Data shared with external entities for measurement purposes or research will be released only in an aggregate form that does not allow direct or indirect participant identification. Identifiable personal information may not be shared with the Fund Office, unless required by law;
- The Board of Trustees will report to the Fund's Privacy Officer any use or disclosure of PHI that is inconsistent with the Fund's Privacy Policy;
- The Fund will allow you to inspect and photocopy your PHI to the extent, and in the manner, required by HIPAA;
- The Fund will make available your PHI for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA;
- The Fund will keep a written record of certain types of disclosures it may make of PHI, so that the Fund can maintain an accounting of disclosures of PHI;
- The Fund will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Fund in order to allow the Secretary to determine the Fund's compliance with HIPAA;
- The Board of Trustees will return to the Fund or destroy all PHI received from the Fund when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the PHI, then the Board of Trustees shall limit its further use or disclosures of any of your PHI that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible;
- The Fund shall ensure that adequate separation will be maintained within the Fund. Only the categories of employees enumerated hereafter and individual Trustees will be permitted to have access to and use the PHI to perform Plan administrative functions. The following categories of employees under the control of the Board of Trustees are the only employees who may obtain PHI in the course of performing the duties of their job with or on behalf of the Board of Trustees: The Executive Director, the Chief Financial Officer, the Director of Operations, the Director of Welfare and Eligibility, and all other Welfare Fund staff routinely responsible for administration of claims for the Fund. Additionally, individual Trustees may receive health information from the Fund in the course of hearing appeals or handling other Plan administration functions;
- If we become aware of any noncompliance with the provisions outlined above by any of the individuals listed above, we will promptly report the violation to the Fund's Privacy Officer and will cooperate to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the individual(s) whose privacy has been violated; and
- You will receive notice if a breach of your PHI occurs.

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

- The Plan Administrator,
- Staff designated by the Plan Administrator, and
- Business Associates under contract to the Plan.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, contact the Fund Office at the number on your ID card.

In compliance with HIPAA Security regulations, the Plan Sponsor:

- Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Plan,
- Will ensure that the adequate separation discussed above, specific to ePHI, is supported by reasonable and appropriate security measures,
- Will ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI, and
- Will report to the Plan any security incident of which it becomes aware concerning ePHI.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits and describes the procedures for appealing denials of claims. The procedures will vary depending on the type of your claim. The Fund has contracted with different claims administrators ("Claims Administrator") to administer different benefits. Read each of the following sections carefully to determine which procedure is applicable to your particular request for benefits.

What Is a Claim?

A claim is a request for benefits made in accordance with the Fund's claims procedures.

What Is Not a 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/herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed amount 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 you will be notified of the decision and allowed to file an appeal; or
- 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 incomplete or lacks required supporting documents, you will be notified about what information is necessary to complete the claim.

How to File a Claim

A claim form may be obtained from the Fund Office by calling (800) 529-3863, visiting the Funds' website at **www.nyccbf.org/member/members-documents/**, or from the Claims Administrator listed on pages 144-145. The claim form should be completed in its entirety and submitted to the Claims Administrator. If a request is filed improperly or the form is incomplete, the request will not constitute a claim under these procedures.

You will only receive notice of an improperly filed claim if the claim includes (i) your name, (ii) your specific medical condition or symptom and (iii) a specific treatment, service or product for which approval is requested. Check the claim form to be certain that all applicable portions of the form are completed. Include with the claim form any **Itemized Bills** if services have already been provided to you or any documentation requested to verify your claim. If the claim forms have to be returned to you for information, delays in processing the claim will result.

A claim form that is incorrectly sent to the Fund Office will be redirected to the Claims Administrator. The applicable time frame for processing the claim will begin to run from the date the claim is received at the Claims Administrator (discussed further below in ***When Claims Must Be Filed***).

Authorized Representatives

An authorized representative, such as your spouse or adult child, may complete the claim form for you if you are unable to complete the form and you 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 Fund may request additional information to verify that this person is authorized to act on your behalf. If an authorized representative is designated, all notices will be provided to you through your authorized representative. The Fund **does not** permit providers, hospitals or facilities to act as your Authorized Representative.

When Claims Must Be Filed

All claims, except life insurance claims, **must be** filed in writing by no later than 365 days (one year) after the date the charges were incurred. Life insurance claims must be filed in writing no later than 730 days (two years) after the date of death. In all circumstances, claims should be filed in writing as soon as possible after the date the charges are incurred. Your claim will be considered to have been filed as soon as it is received by the Claims Administrator that is responsible for making the initial determination of the claim.

Active Employees

The Fund Office will review Paid Family Leave claims for eligibility. If you are determined to be covered by the Fund, the complete application along with all your supporting documents must be submitted to:

Amalgamated Employee Benefits Administrators
P.O. Box 5453
White Plains, NY 10602
Email: **SubmitClaimForms@amalgamatedbenefits.com**

Active and Pre-Medicare Retirees

Hospital, medical and behavioral health claims must be submitted to:

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

Prescription drug claims must be submitted to:

Express Scripts
ATTENTION: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Medicare-Eligible Retirees and Dependents

Hospital, medical and behavioral health claims for Medicare-Eligible Retirees and Dependents must be submitted to:

Medical/Hospital Claims must be submitted to:
UnitedHealthcare
Claims Department
P.O. Box 31362
Salt Lake City, UT 84131-0362

Prescription drug claims must be submitted to:
Express Scripts Medicare
P.O. Box 66535
St. Louis, MO 63166-6588

Active, Pre-Medicare, and Medicare Retirees

Dental claims must be submitted to:
ASO/SIDS
PO Box 9007, Dept. 95,
Lynbrook, NY 11563

Out-of-network vision care, hearing, disability, life insurance, and AD&D claims must be submitted to:
New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
800-529-3863

The Fund Office will review Life Insurance and AD&D claims for eligibility and completeness and then forward the claim to:
Amalgamated Life Insurance Company
Attention: Policy Services
333 Westchester Avenue, N101
White Plains, NY 10604-2910

Time Frames for Decision-Making

The Fund's procedures and time limits for evaluating claims and informing you of the decision will vary depending upon whether your claim is a Pre-Service claim, an Urgent Care claim, a Post-Service claim, or a Disability claim.

Pre-Service claims are benefit requests where approval is required before you receive medical care or obtain a prescription drug, such as pre-certification of an inpatient non-emergency Hospital stay or pre-authorization/pre-certification of a prescription drug.

Urgent Care claims are a special kind of pre-service claim that requires a quicker decision because your health would be threatened if the Fund took the normal time permitted to decide a pre-service claim. If a physician with knowledge of your medical condition tells the Fund that a pre-service claim is urgent, the Fund will treat it as an Urgent Care claim.

Both Pre-Service and Urgent Care claims are specific to Hospital, medical, and behavioral health claims administered by Empire and to prescription drug claims administered by Express Scripts. You will find additional information concerning Pre-Service and Urgent Care claims in the Empire and Express Scripts claim sections that follow.

Most requests for Fund benefits are Post-Service claims. Post-Service claims are claims for benefits where the services have already been provided. Reimbursement requests for a doctor's visit or for the purchase of a hearing aid are examples of Post-Service claims.

Post-Service claims must be decided no later than 30 days after the Fund receives your claim. The Fund may extend the time period up to an additional 15 days if it requires more time to decide your claim. In such a case, you will be notified that additional time is required before the end of the initial 30-day period and the reason for the delay will be explained. If additional information is requested, you will have at least 45 days to supply it. The Fund must decide your claim no later than 15 days after you provide the additional information. The Fund needs your consent to extend the time period after the first extension.

Disability claims must be decided no later than 45 days after the Fund receives the claim. The Fund can extend the time frame for an additional 30 days but it must inform you it needs additional time before the end of the initial 45-day period. If the Fund requests additional information from you, you will have at least 45 days to provide it. The Fund must decide your claim no later than 30 days after you provide the additional information requested.

The Fund may extend the time period for deciding your claim for another 30 days if it notifies you before the first 30-day extension expires. The Fund needs your consent for any further extension beyond the two 30-day extensions noted above.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). A denial of a claim may also include any claim where the Fund pays less than the total amount of expenses submitted. This notice will state:

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

Appeal Process

If a claim is denied (in whole or in part) and you disagree with the decision, you or your authorized representative may appeal. The amount of time you have to appeal, and levels of appeal are summarized in the following chart:

Type of Benefit	Where to Send Appeal	Allowable Amount of Time to Submit Appeal
Hospital, Medical, and Behavioral Health	***First Level-** Empire ***Second Level-** Empire **Optional Third Level-** Appeals Committee of the Board of Trustees ("Appeals Committee")	***First Level**- Within **180** calendar days of notice of adverse benefit determination ***Second Level**- Within **60** calendar days of notice of denial of First Level Appeal **Optional Third Level-** Within **60** calendar days of notice of denial of Second Level Appeal
Prescription Drugs	**First Level-** Express Scripts **Second Level-** Express Scripts **Third Level-** Appeals Committee	**First Level**- Within **180** calendar days of notice of adverse benefit determination **Second Level**- Within **90** calendar days of notice of denial of First Level Appeal **Third Level-** Within **60** calendar days of notice of denial of Second Level Appeal
Dental	**First Level**- ASO/SIDS **Voluntary Second Level** - Appeals Committee	**First Level**- Within **180** calendar days of notice of adverse benefit determination **Voluntary Second Level**- Within **60** days of notice of denial of First Level Appeal
Short-Term Disability, Vision, Hearing	**First and Final Level-** Appeals Committee	Within **180** calendar days of notice of adverse benefit determination
Life Insurance, AD&D	**First and Final Level-** Amalgamated Life	Within **60** calendar days of notice of adverse benefit determination
Hospital, Medical, and Behavioral Health for Medicare-Eligible Retirees and Dependents	UnitedHealthcare	*Please refer to your Evidence of Coverage mailed to you by United Healthcare for more details

Type of Benefit	Where to Send Appeal	Allowable Amount of Time to Submit Appeal
Paid Family Leave	**First Level** (Request for Reconsideration on Payment)- **Amalgamated Employee Benefits Administrators Second Level –** National Arbitration and Mediation **(www.namadr.com)**	**First Level-** within **six** months of notice of adverse benefit determination **Second Level-** Appeal must be filed with National Arbitration and Mediation within **one** year of adverse determination.

*First- and second-level appeals to Empire which do not involve a medical necessity or experimental or investigational determination are referred to as "grievances." Grievances include matters such as requests for additional benefit consideration, issues involving Plan limits and exclusions, and the untimely filing of claims.

Hospital and medical claims:

Empire
Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
844-416-6387

Behavioral health claims:

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

Prescription drug claims:

Express Scripts
P.O. Box 66587
St. Louis, MO 63166-6587
Attention: Benefit Coverage Review Department
800-946-3979

Life insurance and AD&D claims:

Amalgamated Life Insurance Company
Attention: AGD-Claims Appeals Committee
333 Westchester Avenue
White Plains, NY 10604

Dental claims:

ASO/SIDS
P.O. Box 14597
Lexington, KY 40512
Attention: Appeals Coordinator

New York Short-Term Disability claims:

Workers' Compensation Board
Disability Benefits Bureau
100 Broadway – Menands
Albany, NY 12241

New Jersey Short-Term Disability claims:

Division of Temporary Disability Insurance
Private Plan Operations
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625

Continuation of Coverage during Total Disability, Vision, and Hearing claims:

New York City District Council of Carpenters Welfare Fund
Appeals Committee
395 Hudson Street
New York, NY 10014

Paid Family Leave claims:

Amalgamated Employee Benefits Administrators
Attention: PFL Appeals
P.O. Box 5453
White Plains, NY 10602
833-941-1057

Separate sections in this SPD describe in detail the review and appeal procedures used by Empire (page 148), Express Scripts (page 157) and ASO/SIDS Dental (page 161).

Hospital, Medical and Behavioral health claims for Medicare-Eligible Retirees and Dependents:

UnitedHealthcare
Appeals and Grievances Department
P.O. Box 6106, MS CA124-0157
Cypress, CA 90630

How to File an Appeal

Your appeal must be made in writing within 180 days after you receive notice of denial, unless otherwise noted. If the appeal is not submitted within this time frame, the initial decision will stand.

Your Rights in the Appeal Process

- You have the right to review, free of charge, documents, records or other information relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Fund policy regarding the denied treatment or service.
- The appeal will be reviewed by an appropriate named fiduciary who is not the individual who initially denied your claim (or the first-level appeal decision in cases with more than one level of appeal).
- The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional written documents, records and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.
- The health care professional shall be an individual who is neither the individual who was consulted in connection with your original appeal or the subordinate of such individual.
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.

Appeals Heard by the Trustees

Decisions on appeals will be made by the Board of Trustees, or a duly designated Committee of Trustees, at the next regularly scheduled meeting of the Board of Trustees or Committee, following receipt of your written request for review. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your voluntary appeal has been reached, you will be notified of the decision as soon as possible. Once a decision on your mandatory appeal has been reached, you will be notified by no later than five days after the decision has been reached. The appeal decision shall be final and binding on all parties.

Disability Claims

Decisions on appeals involving disability claims will be reached within 45 days of your appeal. However, in special circumstances, up to an additional 45 days may be necessary to reach a final decision on a disability claim. You will be advised in writing within the 45 days after receipt of your appeal if an additional period of time will be necessary to reach a final decision on your disability claim.

Accidental Death and Dismemberment (AD&D) and Life Insurance Claims

Amalgamated will make a decision within 30 days following receipt of your appeal.

Notice of Decision on Appeal

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

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement describing the Fund's voluntary appeal procedures and your right to obtain information about such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal;
- If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge. The use of an independent third party to review a denied appeal is available for claims that were denied based upon a lack of medical necessity or if the claim was denied as investigational or experimental. You cannot use an independent third party to review the payment associated with the claim; and
- If the Fund does not adhere to all the requirements of the appeals procedure with respect to a claim, you may be considered to have exhausted the internal claims and appeals process and entitled to initiate an external review, if applicable. You may also be entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Fund failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If you choose to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. The internal claims and appeals process will not be deemed exhausted based on ***de minimis*** violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Fund demonstrates that the violation was for good cause or due to matters beyond the control of the Fund and that the violation occurred in the context of an ongoing, good faith exchange of information between the Fund and yourself.

GRIEVANCES AND APPEALS FOR CLAIMS ADMINISTERED BY EMPIRE

This section describes the procedures for appealing denials of claims administered by Empire. A complaint, appeal or grievance that is incorrectly sent to the Fund Office must be redirected to Empire. The applicable timeframe for making the decision as set forth below will begin to run from the date of Empire's receipt of the complaint, appeal or grievance.

GRIEVANCE PROCEDURES

A. Grievances. Empire's Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Empire. For example, it applies to contractual benefit denials or issues or concerns you have regarding Empire's administrative policies or access to providers.

B. Filing a Grievance. You can contact Empire by phone at the number on your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. Empire may require that you sign a written acknowledgement of your oral Grievance, prepared by Empire. You or your designee has up to 180 calendar days from when you received the decision you are asking Empire to review to file the Grievance. Empire keeps all requests and discussions confidential and will take no discriminatory action because of your issue. Empire has a process for both standard and expedited Grievances, depending on the nature of your inquiry.

C. Grievance Determination. Qualified personnel will review your Grievance, or if it is a clinical matter, a licensed, certified, or registered Health Care Professional will look into it. Empire will decide the Grievance and notify you within the following time frames:

Expedited/Urgent Grievances:	By phone, within 72 hours of receipt of your Grievance. Written notice will be provided within 72 hours of receipt of your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 30 calendar days of receipt of your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 60 calendar days of receipt of your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of your Grievance.

D. Grievance Appeals. If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal by phone at the number on your ID card, in person, or in writing. you have up to 60 business days from receipt of the Grievance determination to file an Appeal.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. Empire will decide the Appeal and notify you in writing within the following time frames:

Expedited/Urgent Grievances:	Written notice will be provided within 72 hours of receipt of your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	30 calendar days of receipt of your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	60 calendar days of receipt of your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

UTILIZATION REVIEW

A. Utilization Review. Empire reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, please call the number on your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. Empire does not compensate or provide financial incentives to its employees or reviewers for determining that services are not Medically Necessary.

Empire has developed guidelines and protocols to assist Empire in this process. Empire will use

evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for your review upon request. For more information, call the number on your ID card, or visit **www.empireblue.com**.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If Empire has all the information necessary to make a determination regarding a Preauthorization review, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of receipt of the request.

   If Empire needs additional information, it will request it within fifteen (15) calendar days. You or your Provider will then have 45 calendar days to submit the information. If Empire receives the requested information within 45 days, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of its receipt of the additional information. If all necessary information is not received within 45 days, Empire will make a determination within 15 calendar days of the end of the 45-day period allowed to submit the additional information.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if Empire has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 72 hours of receipt of the request.

   If Empire needs additional information, it will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Empire will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 48 hours of the earlier of our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, Empire will make a determination and provide notice to you (or your designee) and your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Empire's receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

C. Concurrent Reviews

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

If Empire needs additional information, it will request it within fifteen (15) calendar days of the receipt of the request. You or your Provider will then have 45 calendar days to submit the additional information. Empire will make a determination and provide notice to you (or your designee) and your Provider, in writing, within fifteen (15) calendar days of Empire's receipt of the additional information or, if Empire does not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, Empire will make a determination and provide notice to you (or your designee) and your Provider within 24 hours of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and Empire has all the information necessary to make a determination, Empire will make a determination and provide written notice to you (or your designee) and your Provider within 72 hours of receipt of the request. If Empire needs additional information, it will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Empire will make a determination and provide written notice to you (or your designee) and your Provider within the earlier of one (1) business day or 48 hours of Empire's receipt of the information or, if Empire does not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Empire at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, Empire will make a determination within 24 hours of receipt of the request and Empire will provide coverage for the inpatient substance use disorder treatment while its determination is pending.

D. **Retrospective Reviews.** If Empire has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify you and your Provider within 30 calendar days of the receipt of the request. If Empire needs additional information, it will request it within 30 calendar days. You or your Provider will then have 45 calendar days to provide the information. Empire will make a determination and provide notice to you and your Provider in writing within 15 calendar days of the earlier of Empire's receipt of all or part of the requested information or the end of the 45-day period.

Once Empire has all the information to make a decision, its failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. **Retrospective Review of Preauthorized Services.** Empire may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Empire upon retrospective review is materially different from the information presented during the Preauthorization review;

- The relevant medical information presented to Empire upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Empire;
- Empire was not aware of the existence of such information at the time of the Preauthorization review; and
- Had Empire been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration. If Empire did not attempt to consult with your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider and in writing.

G. Utilization Review Internal Appeals. You, your designee, and, in retrospective review cases, your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. Empire will acknowledge your request for an internal Appeal which will include the name, address, and phone number of the person handling your Appeal and, if necessary, inform you of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when Empire determines that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, you or your designee must submit:

    - A written statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that Empire approved to treat your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when Empire determines that it has a Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, you or your designee must submit a written statement from your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition:

    - That the Participating Provider recommended by Empire does not have the appropriate training and experience to meet your particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

H. First-Level Appeal.

Preauthorization Appeal. If your Appeal relates to a Preauthorization request, Empire will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate your Provider within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

Retrospective Appeal. If your Appeal relates to a retrospective claim, Empire will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If you are not satisfied with the resolution of your expedited Appeal, you may file a standard internal Appeal or an external review.

Substance Use Appeal. If Empire denies a request for inpatient substance use disorder treatment

that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your Provider file an expedited internal Appeal of our adverse determination, Empire will decide the Appeal within 24 hours of receipt of the Appeal request. If you or your Provider file the expedited internal Appeal and an expedited external review within 24 hours of receipt of our adverse determination, Empire will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external review is pending.

I. **Second-Level Appeal.** If you disagree with the first-level Appeal determination, you or your designee can file a second-level Appeal. You or your designee can also file an external review. **The four (4) month timeframe for filing an external review begins on receipt of the final adverse determination on the first-level of Appeal. By choosing to file a second-level Appeal, the time may expire for you to file for external review.**

A second-level Appeal must be filed within 60 days of receipt of the final adverse determination on the first-level Appeal. Empire will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your Appeal and inform you, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If your Appeal relates to a Preauthorization request, Empire will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If your Appeal relates to a retrospective claim, Empire will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** If your Appeal relates to an urgent matter, Empire will decide the Appeal and provide written notice of the determination to you (or your designee), and where appropriate, your Provider, within 72 hours of receipt of the Appeal request.

External Review

1. If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law. The following types of claims are eligible for the External Review Process: (1) the adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational, or (2) the denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time. Note that the IRO will determine whether a denial involves a medical judgment.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

2. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

3. All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under the Fund. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Voluntary Appeal to the Trustees

If the two levels of appeal with Empire are denied, you then have the option to appeal to the Board of Trustees or duly designated Committee of Trustees. Such appeal must be filed within 60 calendar days of the date of Empire's Level 2 decision.

You are not required to file a voluntary appeal to the Trustees in order to fulfill your appeal procedure obligations. Your decision whether to file such an appeal will not affect your rights to any other benefits under the Fund. The Trustees' decision is final and binding on all parties except for any relief available through ERISA.

Your appeal to the Trustees must be in writing. No verbal appeals will be accepted. Once the appeal is received, the Fund Office will verify if Empire has previously issued a denial. If you have not filed first- and second-level appeals/grievances with Empire, you will have forfeited your right to an optional appeal to the Trustees.

If you or your Beneficiary take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of denial of the appeal or from the deemed denial.

CLAIMS AND APPEALS FOR PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS

This section describes the procedures for filing claims administered by Express Scripts.

A claim or appeal that is sent incorrectly to the Fund Office or other entity must be redirected to Express Scripts. The time frame for making the decision, as set forth below, will begin to run from the date of Express Scripts' receipt of the claim (discussed further below in ***When Claims Must Be Filed***).

How to File a Prescription Claim

If you purchase a prescription drug at an Out-of-Network pharmacy (or from an In-Network pharmacy with the intent to seek reimbursement at a later date), a claim form may be obtained from the Fund Office by calling 800-529-3863 or by logging into Express Scripts' website at **www.express-scripts.com**. The claim form should be completed in its entirety and submitted to Express Scripts. If a request is filed improperly or the form is incomplete, the request will not constitute a claim under these procedures.

You will only receive notice of an improperly filed claim if the claim includes (i) your name, (ii) your specific medical condition or symptom and (iii) a specific treatment, service or product for which approval is requested. Complete all applicable portions of the form and include any Itemized Bills if the prescription has already been provided to you or any documentation requested to verify your claim. If claim forms are returned to you for additional information, claims processing delays will result.

When Claims Must Be Filed

Claims must be filed in writing by no later than one year after the date the charges were incurred. However, you should always file claims as soon as possible after the date the charges are incurred.

Your claim will be considered to have been filed as soon as it is received by Express Scripts. Urgent claims may not be submitted in writing but must be submitted by telephone to Express Scripts.

Where to Submit Your Prescription Drug Claims

Express Scripts
ATTENTION: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Claims Review Process

After you submit a properly completed claim form, Express Scripts decides the claim within the applicable time frames for decision-making.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). A denial of a claim may include any claim where the Fund pays less than the total amount of expenses submitted. This notice will state:

- The specific reasons for the determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim or a statement that it is available upon request at no charge.

Appeal Process

If your claim is denied, you may file an appeal or grievance with Express Scripts. An appeal is a request to have Express Scripts reconsider a denial based on a finding that the service is not Medically Necessary or is considered to be experimental or investigational. A grievance is a request to have Express Scripts reconsider a denial based on any other terms of the Plan.

How to File an Appeal or Grievance

Your appeal or grievance must be made in writing to Express Scripts within 180 days after you receive notice of denial. If the appeal or grievance is not submitted within that time frame, Express Scripts will not review it and its initial decision will stand.

The contact information for Express Scripts is:

Express Scripts
P.O. Box 66587
St. Louis, MO 63166-6587
Attention: Benefit Coverage Review Department
800-946-3979

Time Frames for Appeals Decision-Making

First Level. Express Scripts will complete its review of your written appeal or grievance within 15 days of receipt of the appeal or grievance. If your appeal or grievance is for a submitted paper claim (a direct reimbursement claim for services provided by a non-network pharmacy, or, in some cases, an in-network pharmacy), Express Scripts will complete its review of your appeal or grievance within 30 days of receipt of the appeal or grievance.

Second Level. Your written request must be received within 90 days of the date of the decision on your First-Level appeal or grievance. Express Scripts will complete its review of your appeal or grievance within 15 days of receipt of the appeal or grievance. If your appeal or grievance is for a submitted paper claim (a direct reimbursement claim for services provided by a non-network pharmacy or, in some cases, an in-network pharmacy), Express Scripts will complete its review of your appeal within 30 days of receipt of the appeal or grievance.

Third Level. The third level of appeal is a voluntary procedure. Should Express Scripts deny your Second-Level appeal or grievance, you may file a voluntary third-level appeal with the Trustees. To request this voluntary appeal, or if you have any questions, please call the Fund Office. This third-level appeal is not required by the Fund and is only available if you request it. This third level of appeal must be filed within 60 days of the date of Express Scripts' denial of the Second-Level appeal or grievance.

The voluntary level of appeal is available only after you have pursued the above-described mandatory appeals process. The Fund will not assert a failure to exhaust administrative remedies where you elect to pursue a claim in court rather than through the voluntary appeal. Where you choose to pursue a claim in court after completing the voluntary appeal, any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process.

When and How to Request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an Independent Review Organization ("IRO") with medical experts who were not involved in the prior determination of the claim. The request must be received within four months of the date of the final internal adverse benefit determination, as explained below. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day.)

An external review is available for eligible adverse benefit determinations as described above after the denial of an urgent Level 1 appeal or after the denial of a standard Level 2 appeal. Thus, the external review request must be received within four months of the date of denial of an urgent Level 1 appeal and within four months of the denial of a standard Level 2 appeal.

External review requests must be mailed or faxed to:

Express Scripts
Attention: External Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
800-753-2851 (phone)
877-852-4070 (fax)

How an External Review is Processed

Standard External Review. Express Scripts will review the external review request within five business days to determine if it is eligible to be forwarded to an IRO and you will be notified within one business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within five business days of assigning the IRO. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information that you submit to the IRO will also be sent to Express Scripts for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send you, the Fund and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify you in writing that the claim is ineligible for external review.

Urgent External Review. Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where, in the opinion of the attending Provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and you will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send you written notice of its decision.

Voluntary Appeals to the Trustees

Your appeal to the Trustees must be made in writing. No verbal appeals will be accepted. Once the appeal is received, the Fund will verify if Express Scripts has previously issued a denial. If you have not filed First- and Second-Level appeals with Express Scripts, you will have forfeited your right to a voluntary appeal to the Trustees.

Decisions on appeals involving prescription benefits will be made by the Trustees at the next regularly scheduled meeting following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal 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 appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your appeal has been reached, you will be notified of the decision as soon as possible after the decision has been reached. The Trustees' decision shall be final and binding on all parties.

APPEALS FOR DENTAL BENEFITS

Dental Appeals

There is one mandatory first-level appeal to ASO/SIDS and a voluntary second-level appeal to the Board of Trustees or duly designated Committee of Trustees.

Time Frames for Appeals Decision-making

After you submit a first-level mandatory appeal to ASO/SIDS, ASO/SIDS will complete its review of your appeal and notify you of its decision within **60 days** of receipt of the appeal.

Your appeal to ASO/SIDS must be made in writing. No verbal appeals will be accepted.

If ASO/SIDS denies your appeal, you have the option to appeal to the Trustees. Your voluntary appeal must be filed within 60 days of the date of ASO/SIDS's decision.

Your appeal to the Trustees must be made in writing. No verbal appeals will be accepted. Once the appeal is received, the Fund will verify if ASO/SIDS has previously issued a denial. If you have not timely filed an appeal with ASO/SIDS, you will have forfeited your right to a voluntary appeal to the Trustees.

In order to utilize the voluntary appeal to the Trustees, your appeal must be received within **60 days** of the date of ASO/SIDS's appeal decision. If the appeal is not submitted within that time frame, the Trustees will not review it and ASO/SIDS's decision will stand**.** The Trustees will complete their review of your appeal at their next regularly scheduled meeting following receipt of your written appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal.

You are not required to file a voluntary appeal to the Trustees in order to fulfill your appeal obligations. Your decision whether to file such an appeal will not affect your rights to any other benefits under the Fund. The Trustees' decision is final and binding on all parties except for any relief available through ERISA.

Notice of Decision on Appeal

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

- The specific reasons 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 provisions 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; and
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement that such rule, guideline, protocol or criteria will be provided free of charge, upon request.

Limitations on When and Where a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until you have filed any mandatory appeals and a final decision has been reached on your mandatory appeals, or until the applicable time frame described above has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision (a deemed denial). However, a lawsuit may be started prior to you requesting or submitting a benefit dispute to any voluntary appeal. The law also permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Fund has failed to follow them, or if exhausting your administrative remedies would be futile.

If you or your Beneficiary takes legal action following a denial of an appeal, the lawsuit must be filed within 365 days from the notice of the denial of the appeal or of the date of the deemed denial. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

In addition, any legal or equitable action related to any other claims you may have against the Fund, the Board of Trustees, Committee thereof, or any employee, fiduciary or representative of the Fund must be commenced within 365 days from the date that such claim arose and must be filed in the United States District Court for the Southern District of New York in New York County, New York. Such claims include, but are not limited to, claims related to COBRA, claims for penalties for an alleged failure to provide requested documents, claims to clarify your rights to future benefits under the Plan, and any other claim to which the statute of limitations set forth in ERISA Section 413 does not apply.

APPEALS FOR UNITEDHEALTHCARE

Appeals for UnitedHealthcare

For information regarding appeals and grievances, please refer to your Evidence of Coverage document mailed to you by UHC. You can also contact UHC toll free at (888) 736-7441, 8 a.m. - 8 p.m., Monday – Friday.

For Fast/Expedited Appeals for Medical Care: Call toll free at (877) 262-9203, 8 a.m. - 8 p.m., Monday – Friday.

Written appeals can be sent to UHC at the following address:

UnitedHealthcare
Appeals and Grievances Department
P.O. Box 6106, MS CA124-0157
Cypress, CA 90630

OTHER INFORMATION YOU SHOULD KNOW

Plan Amendments or Termination

The Board of Trustees intends to continue the Welfare Fund indefinitely. However, it reserves the exclusive right to terminate, amend, modify, reduce, suspend your benefits, or increase your cost of benefits under the Plan at any time. Upon termination of the Plan, the Trustees shall apply the monies of the Fund to provide benefits or to otherwise carry out the purposes of the Plan in an equitable manner, until the entire remainder of the Fund has been disbursed.

Representation

No Local Union officer, business agent, employee, employer or employer representative, Fund Office personnel, consultant or individual trustee or attorney is authorized to speak for the Trustees or commit the Board of Trustees on any matter relating to the Fund, without the express written authority of the Trustees.

The Board of Trustees is the named fiduciary that has the discretionary authority to control and manage the administration and operation of the Fund and Trust. The Board shall have the full, exclusive and discretionary authority to make rules, regulations, interpretations and computations, construe the terms of the Fund, and determine all issues relating to coverage and eligibility for benefits. The Board may also take other actions to administer the Fund as it may deem appropriate. The Board's decisions, interpretations and computations and other actions shall be final and binding on all persons.

Plan Interpretation

In carrying out their respective responsibilities under the Plan, the Board of Trustees and any other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan, and to decide any fact related to eligibility for and entitlement to Plan benefits. 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 or capricious.

No Liability for the Practice of Medicine

Neither the Fund nor the Trustees nor any of their designees are 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 by any health care Provider; nor shall any of them have any liability whatsoever for any loss or Injury caused by any health care Provider because of negligence, failure to provide care or treatment, or otherwise.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of Injuries or Illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but

is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, Worker's Compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan may have the right to recover payments it makes on your behalf from a party responsible for compensating you for your Illnesses or Injuries, as permitted by applicable law. When a right to recovery exists, the following will apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, Illnesses and/or Injuries;
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights;
- If you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan;
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan;
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs; and
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by your attorney regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery, in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, Illnesses and/or Injuries;
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, as permitted by applicable law, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence;
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery, as permitted by applicable law. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any

funds recovered by your attorney regardless of whether funds recovered are used to repay benefits paid by the Plan;

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  - The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan, or
  - You fail to cooperate;
- If you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan;
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, to the extent permitted by applicable law, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you; and
- The Plan is entitled to reimbursement from any Recovery, to the extent permitted by applicable law, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the Plan promptly of how, when, and where an accident or incident resulting in personal Injury or Illness to you occurred and all information regarding the parties involved;
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. If you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan;
- You must not do anything to prejudice the Plan's rights;
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or Illness to you;
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf;
- The Board of Trustees has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of the Plan in its entirety and reserves the right to make changes as it deems necessary;
- If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of Injuries sustained by the covered person, that Recovery shall be subject to this provision;

- The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies; and
- The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Fraud or Otherwise Improper Use of Coverage

The authority to determine whether you have engaged in fraud or whether an ineligible dependent used coverage to which the individual was not eligible rests with the Board of Trustees, in its sole discretion. If the Board of Trustees determines that you or another individual have committed fraud or used coverage to which you were not entitled, you and all of your dependents will be permanently ineligible for Active and/or Retiree Welfare coverage.

Any individual who is determined, in the sole discretion of the Board of Trustees, to have defrauded the Welfare Fund or assisted another individual or entity to defraud the Welfare Fund in any form or manner or any participant whose ineligible dependent used coverage to which the individual was not entitled will be permanently ineligible for Active and/or Retiree Welfare coverage. The participant's dependents will also be permanently ineligible for Active and/or Retiree Welfare coverage. For example, if you are determined, in the sole discretion of the Board of Trustees, to have worked "off the books," you and your dependents will be permanently ineligible for Active and/or Retiree Welfare coverage. Working "off the books" is a situation in which an employer and an employee conspire or otherwise agree or arrange that the actual number of hours worked by the employee will not be reported to the Welfare Fund.

Another example which will result in the loss of coverage is if you and/or your former spouse fail to notify the Fund of your divorce, or if you misrepresent your marital status and your former spouse continues to use coverage under the Fund. In that event, you and your dependents will be permanently ineligible for coverage unless you or the ineligible dependent promptly reimburse the Fund the full amount of claims paid on behalf of the ineligible individual plus interest and collection costs. Even if the claims are paid on behalf of an ineligible dependent or your ex-spouse, you will be considered the responsible party if the person incurring the claims does not reimburse the Fund.

The termination of Welfare Fund coverage due to fraud or the improper use of coverage by an individual (such as a former spouse or other ineligible dependent) will be effective as soon as administratively practical following the Fund's determination of fraud or improper use of coverage and the issuance of written notice of the determination to you and your dependents. Depending on the circumstances, you may be required to reimburse the Fund for any benefits it paid on behalf of you or your dependents during the period at issue.

If you and your dependents become ineligible for Welfare Fund coverage due to a determination that you committed fraud, neither you nor your dependents will be entitled to elect COBRA Continuation Coverage since loss of coverage in these circumstances is not a Qualifying Event under COBRA.

Because illegal activity adds to everyone's cost for healthcare, we welcome your help in fighting fraud. If you know of any person receiving benefits who is not entitled, call the Fund's Chief Compliance Officer at 646-484-1665 or email at **complianceandethics@nyccbf.org**. You can also call Empire's Fraud Hotline at 800-I-C-FRAUD (423-7283) during normal business hours. Your identity will be kept confidential. To see recent examples of Empire's fraud prevention efforts, you can visit **www.empireblue.com**.

Recovery of Overpayments

If a payment to you or your dependent or a Provider is determined to have been paid in error or otherwise be an overpayment, the Trustees may commence legal action to recover the overpayment as well as interest and fees incurred in pursuing the recovery and/or offset future claim payments to recover the amount overpaid. If the overpayment is not returned, the Fund may terminate your coverage and the coverage of your dependents until the overpayment is recovered.

Other Administrative and Funding Information

This section provides information about third parties involved in providing and administering benefits.

Medical and behavioral health benefits. Benefits for Active Employees and Pre-Medicare Retirees are self-funded; that is, they are paid out of Fund assets. The Fund has contracted with Empire to administer the In-Network and Out-of-Network programs on its behalf.

In addition to forwarding to Empire amounts required to pay benefits, the Fund also pays Empire an administrative fee. Empire assumes the responsibility for providing the benefits called for under its contract. Empire may be contacted at:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
844-416-6387
www.empireblue.com

Prescription drug benefits. Benefits are paid out of Fund assets. The Fund has contracted with Express Scripts to administer the program on its behalf. In addition to forwarding to Express Scripts the amount required to pay benefits, the Fund also pays Express Scripts an administrative fee. Express Scripts can be reached at:

For Non-Medicare-Eligible Participants:
Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063
Attention: Administrative Reviews
800-939-2091 (phone)
888-235-8551 (fax)
www.express-scripts.com

For Medicare-Eligible Participants:
Express Scripts
P.O. Box 630406
Irving, TX 75063
Attention: Medicare Admin Appl
800-311-2757 (phone)
888-235-8551 (fax)

Dental Benefits. Benefits are paid out of Fund assets. The Fund has contracted with ASO/SIDS, to provide claims and other administrative services. The Fund pays ASO/SIDS a fee for these administrative services, plus the amounts required to pay benefits. The dental administrator can be contacted at the following addresses:

Administrative Services Only, Inc.
Self-Insured Dental Services ("ASO/SIDS")
P.O. Box 9005
Lynbrook, NY 11563
Telephone: 800-537-1238
Website: **http://www.asonet.com**

Vision care benefits and hearing benefit. Benefits under these programs are paid out of Fund assets. The Fund has contracted with General Vision Services ("GVS") and Comprehensive Professional Systems ("CPS") to provide access to Participating Providers and other administrative services. The Fund pays GVS and CPS a negotiated fee.

GVS can be reached at the following address:
General Vision Services
520 Eighth Avenue
Ninth Floor
New York, NY 10018
212-594-2580

CPS can be reached at the following address:
Comprehensive Professional Systems, Inc.
11 Hanover Square
Eighth Floor
New York, NY 10005
212-675-5745

Life insurance and accidental death & dismemberment insurance. Benefits are insured by Amalgamated Life Insurance Company ("Amalgamated"). The Fund pays premiums to Amalgamated for the coverage and Amalgamated assumes responsibility for the payment of benefits. Contact info:

Amalgamated Life Insurance Company
Attention: Policy Services
333 Westchester Avenue, N101
White Plains, NY 10604-2910
914-367-5000

New York State Paid Family Leave. Benefits are paid out of Fund assets. The Fund has contracted with Amalgamated Employee Benefits Administrators ("AEBA") to provide claims and other administrative services. The Fund pays AEBA a fee for these administrative services, plus the amounts required to pay benefits. AEBA can be contacted at:

Amalgamated Employee Benefits Administrators
P.O. Box 5453
White Plains, NY 10602

Short-Term Disability Benefits. Benefits under the Short-Term Disability Plan are paid out of Fund assets and administered through the Fund Office.

Scholarship and Recognition Programs. Scholarship benefits are paid out of Fund assets and administered through the Fund Office and International Scholarship and Tuition Services ("ISTS").

UnitedHealthcare. Benefits for Medicare-eligible retirees and dependents are insured. The Fund has contracted with UnitedHealthcare to administer the Group Medicare Advantage ("PPO") Plan on its behalf.

UnitedHealthcare
PO Box 30555
Salt Lake City, UT 84130-0555

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all participants are entitled to certain rights, as outlined in the following information.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a copy 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 Employee Benefits Security Administration ("EBSA").
- Obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD (the Plan Administrator may make a reasonable charge for the copies).

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, Spouse or Dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependent(s) may have to pay for such coverage.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your application for a 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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. If you or your Beneficiary decide to take legal action following a denial of an appeal, the lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York within 365 days from the notice of the denial of the appeal or the deemed denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in the United States District Court for the Southern District of New York in New York County, New York. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have an application for benefits that is denied or ignored, in whole or in part, you may file suit subject to the limitations above in the United States District Court for the Southern District of New York in New York County, New York. 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 Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of EBSA, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by calling 866-444-3272 or visiting EBSA's website at **www.dol.gov/ebsa**.

PLAN FACTS

Official Plan Name	New York City District Council of Carpenters Welfare Fund
Employer Identification Number (EIN)	13-5615576
Plan Number	501
Plan Year	July 1 – June 30
Type of Plan	Welfare benefit plan providing medical, hospital, hearing, vision care, disability, NYS paid family leave, prescription drug, dental, life insurance, and vacation benefits.
Funding of Benefits	Contributions to the Welfare Fund are made by employers in accordance with collective bargaining agreements and participation agreements in force with the District Council, the Fund, or related organizations. These agreements require contributions to the Fund at fixed rates. A copy of any such agreement may be requested or examined at the Fund Office.
Trust	Contributions to the Fund are held in a trust under The Agreement and Declaration of Trust establishing the New York City District Council of Carpenters Welfare Fund, as the same may be amended from time to time. The custodian for the Trust is The Bank of New York.
Plan Administrator	The Welfare Fund is administered by a Board of Trustees composed of ten trustees: five designated by employer associations and five designated by the District Council. Their names appear later in this SPD. The office of the Board of Trustees may be contacted at: Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300
Plan Sponsor	The Welfare Fund is sponsored by the Board of Trustees. The office of the Board of Trustees may be contacted at: Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300
Trustees	Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300
Contributing Employers	The Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Fund and the address of such employer. Additionally, a complete list of employers and Unions participating in the Fund may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.

Agent for Service of Legal Process	Executive Director New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 Legal process may also be served on the Plan Administrator or the individual Trustees.

MEMBERS OF THE BOARD OF TRUSTEES

Union Trustees Designated by the District Council

	Title	Address
Joseph Geiger	Co-Chairman New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Paul Capurso	Trustee New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
David Caraballoso	Trustee New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Michael Cavanaugh	Trustee New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
John Sheehy	Trustee New York City and Vicinity District Council of the United Brotherhood of Carpenters and Joiners of America	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014

Employer Trustees Designated by Employer Associations

	Title/Employer Association	Address
David Meberg	Co-Chairman Greater New York Floor Coverers Association	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
John DeLollis	Trustee Association of Wall-Ceiling and Carpentry Industries of New York, Inc.	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Kevin O'Callaghan	Trustee The Hoist Trade Association	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
John O'Hare	Trustee The Building Contractors Association	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Michael Salgo	Trustee The Cement League	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014

GLOSSARY

Active Employee	An individual who works for an employer that has an agreement with the Fund that requires contributions to this Plan and who has met the Fund's eligibility requirements for Active plan participation.
Adverse Determination	A determination that reduces or denies benefits.
Allowed Amount or Maximum Allowed Amount	The maximum charge the Plan recognizes for any service and on which plan payments are based.
Ambulatory Surgery	See "'Same-Day Surgery."
Annual Out-of-Pocket Maximum	The most you will have to pay in out-of-pocket costs for Deductibles, Copayments, and Coinsurance on Covered Services received during a calendar year. When you meet the Annual Out-of-Pocket Maximum, the Plan pays 100% of the Maximum Allowed Amount for covered expenses for the remainder of that calendar year. Any amount you pay above the Out-of-Network Maximum Allowed Amount does not count toward your Annual Out-of-Pocket Maximum.
Authorized Services	See "Precertified Services."
Children	Your eligible Children, until the end of the month in which the Child reaches age 26, including your biological Child, adopted Child (including a Child who has been placed with you for adoption) or stepchild.
Copayment	The fee you pay for office visits and certain Covered Services when you use Network Providers. The Plan then pays 100% of remaining covered expenses.
Covered Employment	Employment by an employer required to contribute to the Fund on your behalf pursuant to a collective bargaining agreement or a participation agreement.
Covered Services	The services for which Providers provides benefits under the Fund's rules, such as one In-Network annual physical exam.
Deductible	The dollar amount you must pay each calendar year before the Plan pays benefits for covered In-Network and Out-of-Network services. If you have family coverage, once any family member meets his/her individual Deductible, the Plan will pay benefits for that family member. However, the benefits for other family members will not be paid until three or more eligible family members meet the family Deductible. Once the family Deductible is met, the Fund will pay benefits for covered In-Network or Out-of-Network services for the remainder of the year for all eligible family members. There are separate In-Network and Out-of-Network Deductibles.
Disabled Child or Children	Your unmarried Child of any age who is incapable of self-sustaining employment due to physical or mental handicap. The handicap must begin before age 26 when coverage for the Child would usually end. A Child must be receiving Social Security Disability benefits to be considered incapable of self-sustaining employment.

Gene Therapy	Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not cover any charges related to gene therapy, whether those therapies have received approval from the FDA or are considered experimental or investigational. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell ("CAR-T") Therapies such as Kymriah and Yescarta, as well and Luxturna and Zolgensma, but new applications for gene therapies are submitted every year.
Health Organization	The companies that provide offerings to clinical authorities like nurses, doctors, pharmacists, etc. Their fundamental purpose is to provide well-being services at lower prices and in better amounts so that these may available to a large number of individuals. A health system, sometimes referred to as health care system or healthcare organization, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.

Hospital/Facility	For purposes of certifying inpatient services, a Hospital or Facility must be 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 or another BCBS plan. For physical therapy purposes, the definition of a "Hospital" may include a rehabilitation Facility either approved by Empire or participating with Empire or another BCBS 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 BCBS plan. In other states, the Facility must participate with another BCBS 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. *(continued)*

Hospital/Facility *(continued)*	For behavioral healthcare 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 healthcare services. For alcohol and/or substance abuse 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. Empire 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.
Illness	Any sickness, disorder, or disease. Pregnancy is treated in the same manner as an Illness under this Plan for you or an eligible dependent.
In-Network Benefits	Benefits for Covered Services delivered by Network Providers and suppliers. Services provided must fall within the scope of their individual professional licenses.
In-Network Coinsurance	Percentage of the Allowed Amount that you must pay for certain In-Network services. Once you meet your annual In-Network out-of-pocket maximum, the Plan will pay 100% of Empire's Maximum Allowed Amount. Refer to the Schedule of Benefits for your In-Network Coinsurance and out-of-pocket maximum amounts.
In-Network Provider/Supplier	A doctor, other professional Provider, or durable medical equipment, home health care or home infusion supplier who: • Is in Empire's POS network • Is in the PPO network of another BCBS plan • Has a negotiated rate arrangement with another BCBS plan that does not have a PPO network
Injury	A bodily Injury resulting directly from an accident and independently of other causes, which occurs while you are covered under this Plan.
Itemized Bill	A bill from a Provider, Hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and Hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A Provider bill will also have the Provider's name and address and descriptions of each service, while 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. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.

Medically Necessary	Services, supplies or equipment provided by a Hospital or other Provider of health services that are: • Consistent with the symptoms or diagnosis and treatment of the patient's condition, Illness or Injury, • In accordance with standards of good medical practice, • Not solely for the convenience of the patient, the family or the Provider, • Not primarily custodial, and • The most appropriate level of service that can be safely provided to the patient. The fact that a Network Provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it Medically Necessary.
Non-Participating Hospital/Facility	A Hospital or Facility that (1) does not have a contract with Empire or another BCBS plan to provide services to persons covered under Empire's POS or PPO contract, or (2) does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.
Operating Area	Empire 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 Providers and suppliers. Out-of-Network benefits are subject to a Deductible and Coinsurance and generally have higher out-of-pocket costs.
Out-of-Network Coinsurance	Percentage of the Allowed Amount that you must pay for certain Out-of-Network services. Once you meet your annual Out-of-Network out-of-pocket maximum, you will not be required to pay any additional cost-sharing, but you will be responsible to pay the difference between the Provider's actual charge and Empire's Allowed Amount. Refer to Your Schedule of Benefits section for your Out-of-Network Deductible, Coinsurance, and out-of-pocket maximum amounts.
Out-of-Network Providers/Suppliers	A doctor, other professional Provider, or durable medical equipment, home health care or home infusion supplier who: • Is not in Empire's POS network • Is not in the PPO network of another BCBS plan • Does not have a negotiated rate with another BCBS plan
Outpatient Surgery	See "Same-Day Surgery."
Participating Hospital/Facility	A Hospital or Facility that: • Is in Empire's POS network • Is in the PPO network of another BCBS plan • Has a negotiated rate arrangement with another BCBS plan that does not have a PPO network
Plan Administrator	The Board of Trustees

Precertified Services	Services that must be coordinated and approved by Empire's Medical Management, Behavioral Healthcare Management, or MEND Programs before you receive them to be fully covered by the Plan (subject to Plan rules).
Provider	A Hospital or Facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for Covered Services within the scope of the practitioner's license. For behavioral healthcare purposes, "Provider" includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof. 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. For maternity care purposes, "Provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed Facility and whose services are provided under qualified medical direction.
Retiree	Any eligible participant who is not currently eligible using bank hours, including participants eligible under the ***Disability Pension.***
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 covered visits for certain treatments. When a service is covered both in and out-of-network, the number of in- and out-of-network visits are combined when counting toward the maximum.

New York City District Council of Carpenters
BENEFIT FUNDS
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