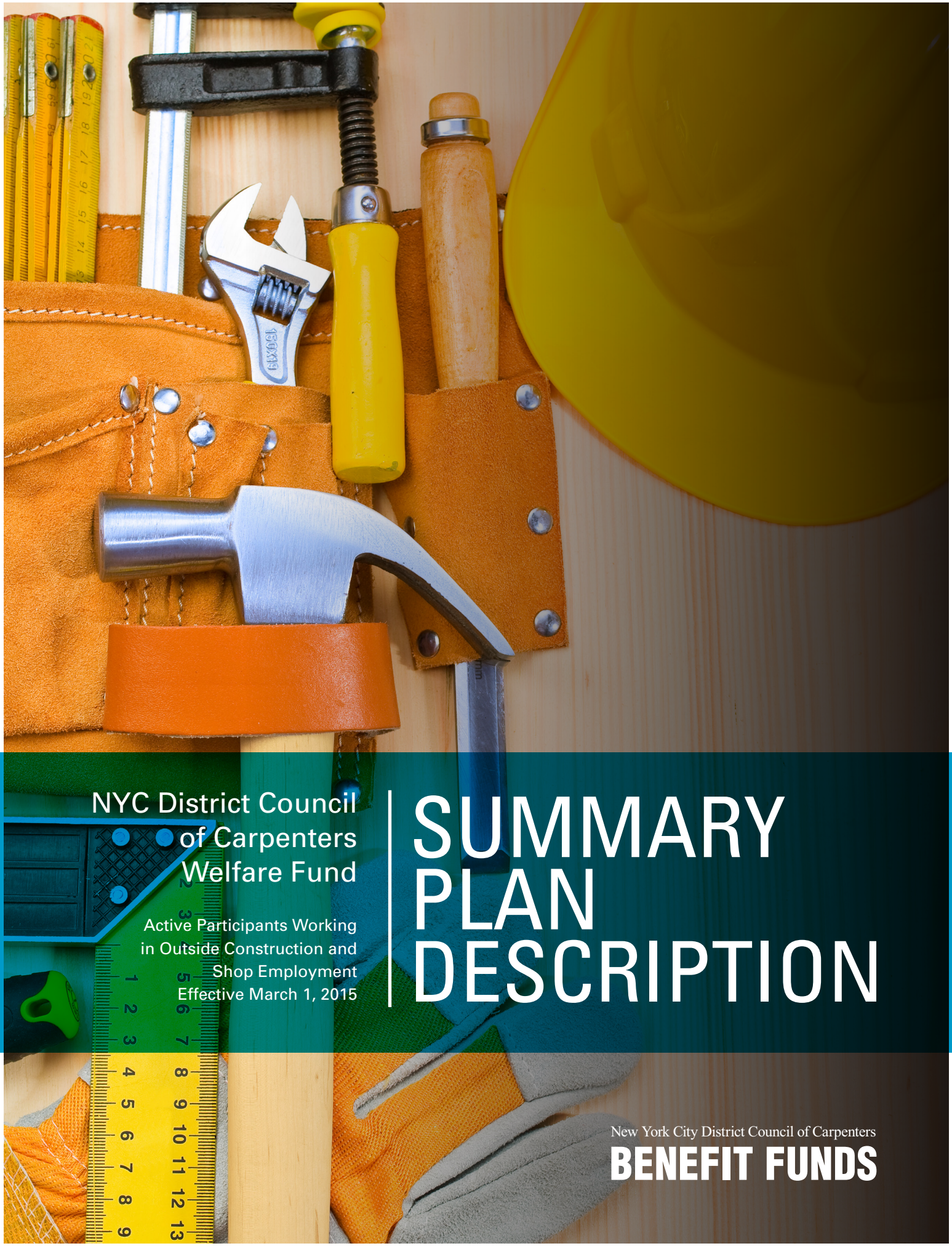

NYC District Council of Carpenters Welfare Fund

Active Participants Working in Outside Construction and Shop Employment
Effective March 1, 2015

SUMMARY PLAN DESCRIPTION

New York City District Council of Carpenters
BENEFIT FUNDS

New York City District Council of Carpenters Welfare Fund

Summary Plan Description

Active Participants Working in Outside Construction and Shop Employment

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TABLE OF CONTENTS

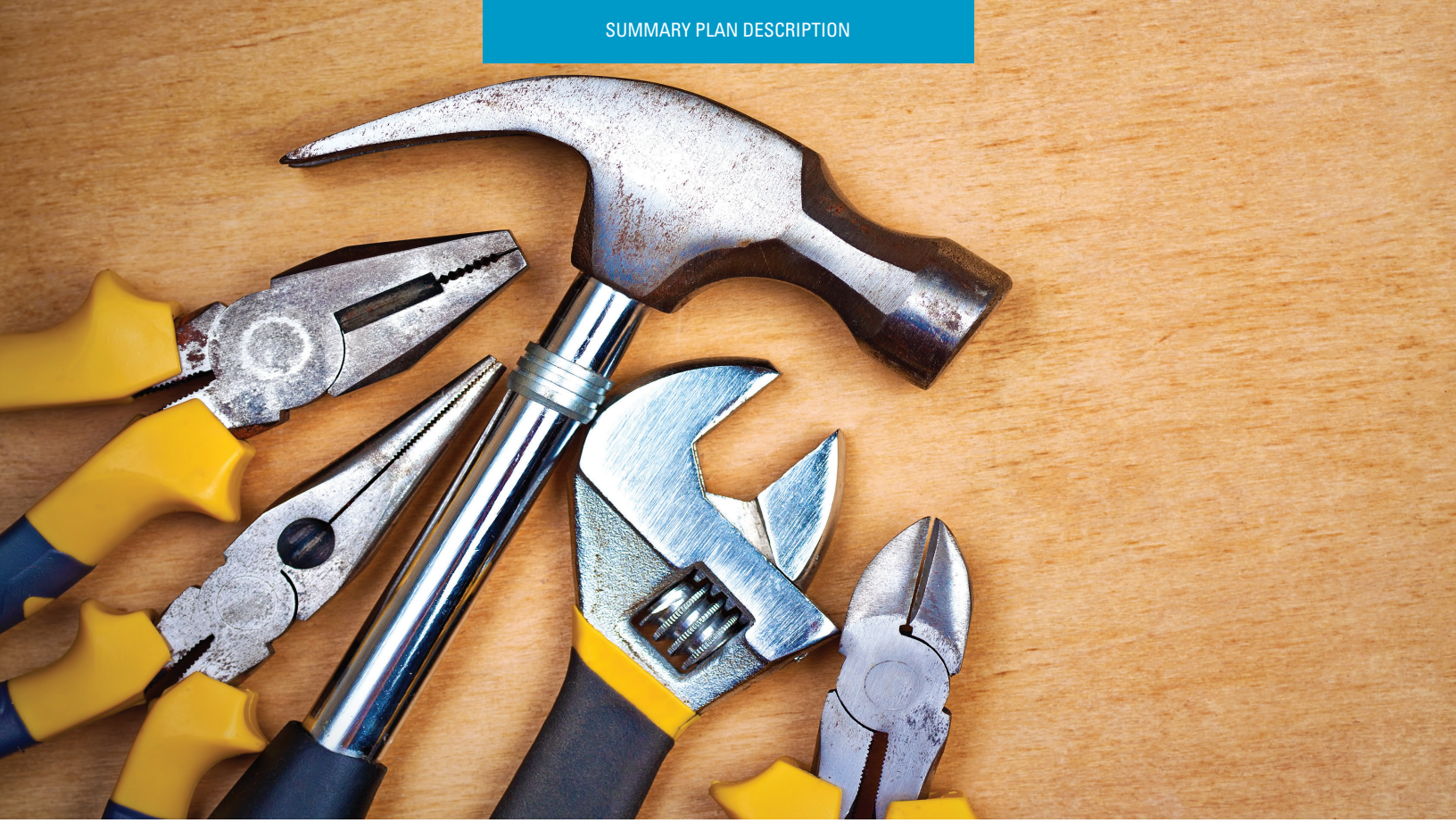
ABOUT THIS BOOK

This booklet summarizes the benefits provided by the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund," the "Fund," the "Plan," or the "Benefit Plan") as of March 1, 2015. It serves as both the Plan document and the Summary Plan Description (the "SPD"). It supersedes all prior SPDs. It also supersedes all Summaries of Material Modifications ("SMMs") issued prior to this SPD. 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 benefits and/or procedures under one or more of the programs that make up the Fund. When that happens, either the administrator of the affected program or the Fund Office will notify you in writing of any change through an SMM. You should keep these SMMs with this booklet. SMMs will be sent directly 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.

This SPD uses everyday language to explain your Welfare Fund benefits; however, there are certain technical terms that apply to the Fund. To make sure you understand these terms, we have defined them in the ***Glossary*** section at the end of the SPD and the first time they appear, they are in **bold** type. Words that are capitalized in this summary – such as "Active Employee," "Retiree" 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.

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 5:30 p.m., lunes a jueves, y 8:00 a.m. a 5:00 p.m. en 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 that includes:

- Health care coverage with medical, **Hospital**, doctors and other necessary medical services, mental health services, and prescription drug, dental, vision care and hearing benefits;
- Disability benefits that help protect you in the event that **Illness** or **Injury** prevents you from working;
- Life insurance benefits that help protect your family in the event of your death;
- A scholarship program that can provide financial assistance for your Child's education; and
- A vacation benefits program (described in a separate SPD).

This booklet offers a comprehensive resource you can use when you or your family members need information about any of the benefit programs. 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.

For More Information:

About your . . .	Contact . . .
Health Care Coverage • Medical Care • Mental Health and Substance Abuse Treatment	**Empire BlueCross BlueShield** 800-553-9603 www.empireblue.com
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.** 212-675-5745 https://cpshearing.com or www.cpsoptical.com **General Vision Services** 212-594-2580 www.generalvision.com/hearing
Dental Benefits	**Aetna** 855-201-8436 www.aetna.com
Life Insurance Coverage	**Guardian Life Insurance Company** 800-525-4542
Disability Coverage	**Fund Office** 800-529-3863 or 212-366-7373 www.nyccbf.org
Scholarship and Recognition Program	**International Scholarship and Tuition Services (ISTS)** 855-670-4787 https://aim.applyists.net/NYCDCC
Vacation Benefits	**Fund Office** 800-529-3863 or 212-366-7373 www.nyccbf.org

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. The different rules that apply for Short-Term Disability 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. Two-hundred and fifty (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 any payment. At the beginning of each calendar quarter, the Fund Office notifies 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. This is the minimum number of hours required for a 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 does, 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 or not work you performed constituted work for a Contributing Employer in Covered Employment, you bear the burden of proving that work performed was for a Contributing Employer and was in Covered Employment. Your employer's report of your earnings to the Social Security Administration may be insufficient to prove that work performed was in 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 Fund benefits. The Trustees reserve the right to determine whether evidence submitted by you is adequate to prove that service was performed in Covered Employment for a Contributing Employer.

BENEFIT SHORTAGES

It is very important for you to regularly check that all of the hours you work 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 not reporting the hours you work in Covered Employment or is reporting your hours incorrectly. Benefit Hours Shortage Report forms are available at **www.nyccbf.org/member/benefit-shortages/**.

You must submit copies of your pay stubs along with your completed Benefit Hours Shortage Report. Mail your completed Reports and pay stubs 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 can also be faxed to 212-366-7830. 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

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	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 January 1, the participant has 100 bank hours available. Since the participant has less than 250 bank hours available, the participant is not eligible during the January – March quarter. The participant works 200 hours in Covered Employment during the January – March quarter but the employer never reports the hours. The participant doesn't check his/her hours regularly because he/she doesn't use his/her coverage often and is unaware that the 200 hours have not been properly credited. The participant still has only 100 hours available at the start of the calendar quarter beginning April 1 and therefore remains ineligible for the April – June period.

The participant works 75 hours in Covered Employment during the middle of June. These 75 hours are reported by the employer and properly credited to the participant. Toward the end of June, the participant schedules a medical appointment for mid-July believing that the 75 hours he/she just worked, when added to the 200 hours he/she worked during the first quarter, would establish his/her eligibility for coverage during the calendar quarter beginning July 1.

In July, prior to the appointment, the medical office calls the participant and informs him that when it called Empire BlueCross BlueShield ("Empire") to verify eligibility, Empire advised the medical office that the participant wasn't eligible. At that point (in July), the participant calls the Fund Office and first learns that the 200 hours he/she worked during January – March were never reported.

The participant files 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 the participant's eligibility status for the same three quarters after the Shortage Report was submitted and determined to be valid.

BENEFIT SHORTAGES – EXAMPLE TWO

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 the participant wanted to establish eligibility for the July – September quarter, the 200 hours when properly credited established eligibility for the April – June quarter. The participant remains ineligible for the July – September quarter.

Remember: Check your hours regularly so you can ensure that all hours you worked in Covered Employment are properly credited to you—and if not, so you can 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 money, your employer must remit payment for the required benefit 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.

FRAUD

The authority to determine whether you have engaged in fraud rests with the Board of Trustees. If the Board of Trustees determines that you have committed fraud, you and all of your dependents will be permanently ineligible for Active or **Retiree** Welfare coverage.

Any participant, including, but not limited to, a Union official, shop steward, foreman, owner or employee, 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, will be permanently ineligible for Active or Retiree Welfare coverage. The participant's dependents will also be permanently ineligible for Active or Retiree Welfare coverage.

In addition, if you are determined, in the sole discretion of the Board of Trustees, to have worked "off the books," you will be ineligible for Active or Retiree Welfare coverage. Your dependents will also be permanently ineligible for Active 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. If it is determined that you worked "off the books," you and your dependents will be permanently ineligible for Active or Retiree Welfare coverage.

The termination of Welfare Fund coverage due to fraud will be effective as soon as administratively practical following the Trustees' determination of fraud and the issuance of written notice of the Trustees' 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 due to fraud is not a qualifying event under COBRA.

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.

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 Welfare Fund coverage to continue after your bank hours are used, you must qualify for Retiree health coverage.

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 satisfy one of the three requirements below:

- You have earned at least 30 Vesting Credits with the New York City District Council of Carpenters Pension Fund (the "Pension Fund"); or
- You have earned at least 20 Vesting Credits under 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 under 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.

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, you will not "bank" hours unless you work enough hours so that your pension is suspended.

Your coverage as a Retiree will continue for up to six consecutive months if you work at least 40 hours in Covered Employment in each of those six months. During this six-month period, you will begin accumulating hours in your bank toward future eligibility. (Note that a special coverage extension rule for Disability Pensions is discussed in the following section.)

Disqualifying Employment Rules

Under the Welfare Fund's Disqualifying Employment Rules, if you work in Disqualifying Employment while you are covered as a Retiree, you will lose your Welfare Fund Retiree coverage temporarily and, in some cases, permanently.

If you work even one hour per month in Disqualifying Employment under the Welfare Fund, you are subject to the Welfare Fund's Disqualifying Employment Rules. On the other hand, you may work an unlimited number of hours in any employment that is not Disqualifying Employment.

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 for an employer who is not required to contribute to the Welfare Fund on your behalf.

You must notify the Welfare Fund in writing if you intend to work in Disqualifying Employment in advance. If possible, you should notify the Fund Office at least 30 days in advance of the Disqualifying Employment, but no later than the first day of your Disqualifying Employment.

If you would like the Welfare Fund to review any potential employment you are considering to determine its impact on your Retiree coverage, please complete and submit the Reemployment Questionnaire, which can be obtained by contacting the Fund Office.

It is important to note that the Welfare Fund's Disqualifying Employment Rules are significantly different from the Pension Fund's suspension of benefit rules.

For more information, contact the Fund Office.

Disability Pensioners

You may be eligible for Retiree health coverage as a Disability Pensioner provided that you satisfy certain conditions.

If you become Totally Disabled while you are an eligible Active Employee, your Fund coverage will remain in effect for as long as you remain disabled. This benefit does not provide a cash benefit.

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

1. You are unable to work in Covered Employment due to an Illness or Injury,
2. You have accrued at least five Vesting Credits in the Pension Fund as of the date of your disability, and
3. You have been awarded a Phase I Disability Pension from the Pension Fund.

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 six 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. Keep in mind that this extension is only available if you satisfy the requirements below, including the 20 Vesting Credits requirement.

After 24 months, 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 federal Social Security Disability Award,
2. You have accrued 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, any remaining hours in your bank are used to continue your coverage as an Active Employee. Once the hours in your bank are used up, you will be treated like a Retiree by the Fund and you will be required to pay a monthly premium for your coverage. In addition, there are other coverage differences between the Active and Retiree Benefit Plans. Call the Fund Office for more information. The Pre-Medicare Retiree and Medicare Supplemental Retiree levels of coverage are not described in this SPD.

If your Disability Pension is suspended because you recover or you no longer qualify, 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 if 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.

DEPENDENT COVERAGE

If you are covered, your eligible dependents may be covered for medical, hospital, prescription, dental, vision care, hearing and dependent life insurance benefits. Eligible dependents include your:

- *Spouse* to whom you are legally married. In the event of a same sex marriage, you are considered legally married to your spouse if you were lawfully married in a state or other foreign or domestic jurisdiction whose laws authorize the marriage of two individuals of the same sex, even if you now live in a jurisdiction that does *not* recognize same sex marriages;
- ***Children***, until the end of the month in which they reach age 26; and/or
- *Dependent parents* who live in the United States and whom you claim as dependents on your federal income tax return if you are not married and have no eligible Children.

Under the Fund, Children include:

- Your biological Children;
- Your stepchildren;
- Your legally adopted Children or Children placed for adoption, including Children placed in your home by a licensed placement agency for the purpose of adoption or Children who have been living in your home as foster Children, and for whom foster care payments are being made and a petition for adoption has been filed;
- Children for whom you are the court-appointed legal custodian or guardian and for whom you are required to provide support. All court orders must meet certain requirements that vary from state to state; and/or
- Your unmarried Children, regardless of age who are incapable of self-sustaining employment because of disability, and who became disabled prior to reaching the age at which the dependent coverage would otherwise terminate. If your Child is over age 26, he/she must have a Social Security Disability Award to be eligible for continued Fund coverage.

Coverage for your eligible dependents starts at the same time as your coverage, provided you complete the required enrollment documents. Coverage for your enrolled dependents is the same medical, hospital, prescription drug, vision care, dental and hearing coverage that you receive. Each eligible dependent also receives $1,000 of Life Insurance (but not Accidental Death & Dismemberment Insurance), which is payable to you if the dependent dies.

To make sure coverage for your dependents starts at the same time as your coverage, you need to provide enrollment documents to the Fund Office. You must provide, as applicable:

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.
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 over age 26, he/she must have a Social Security Disability Award 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.

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 ***Changes in Status*** below.

*** 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 will need to 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.

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. If the Fund receives such an order, its status is reviewed by the Fund in accordance with the Fund's QMCSO procedures. For more information on QMCSOs, please contact the Fund Office.

Changes in Status

After your coverage under the Fund begins, it is important 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 changes in status described below:

- Marriage, divorce or annulment;
- 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.

If you have coverage when a Child is born, your newborn will automatically be covered for 30 days from the date of birth. To continue coverage for the Child beyond that time, you need to enroll the Child. Call the Fund Office at 800-529-3863 and provide a copy of the Child's birth certificate and Social Security Card as soon as they are available.

What Happens if You Get Divorced?

If you get divorced, you are responsible for notifying the Fund Office within 60 days and submitting a copy of your divorce judgment. You and your former spouse will be jointly and severally liable for any amounts paid on behalf of your former spouse or stepchild following a divorce. In addition to having to repay the Fund the costs of any benefits provided on behalf of such former spouse or stepchild, the Trustees have the sole discretion to permanently terminate your eligibility and the eligibility of your Eligible Dependent(s) if you fail to notify the Fund Office of your divorce.

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.

The Fund complies with the special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In addition, you and your dependents may also enroll in this Fund if you (or your dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and you (or your dependents) lose eligibility for that coverage; or
- Become eligible for a premium assistance program through Medicaid or CHIP.

Dis-enrolling Covered Dependents

Spouse. If your spouse wants to utilize his/her own coverage, it is not necessary for him/her to dis-enroll as his/her coverage will be primary regardless. An individual's health coverage issued by his/her employer is always primary. The Welfare Fund coverage can remain as your spouse's secondary coverage. In such instances, you should contact the appropriate Health Organization directly to update your "Coordination of Benefits" status as soon as possible. (See page 99.)

Children. When a Child has group health coverage under the plans of both parents and the Fund's coverage would be the Child's primary insurance (see the birthday rule, page 99), you have the option of dis-enrolling your Child from the Fund's coverage when the Fund's Copayments and coinsurance are considerably more than what they are 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 "Special Enrollment" rights that he/she may have under HIPAA. If your Child is employed and has group health coverage on the basis of his/her employment, you must contact the Fund's third-party administrators directly and update your Child's Coordination of Benefits status as soon as possible (see page 99). 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 written permission from the Center for Medicare and Medicaid Services.

Coverage Following Death

If you die while an eligible Active Employee, 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 definition above in order to maintain their coverage. The Welfare Fund requires that a monthly premium be paid for this coverage. The premium in effect when this SPD was issued is $50.00 per month. The Welfare Fund may change the amount of the required premium from time to time.

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

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 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 become available. (See page 19 for more information about COBRA.)

In addition, the National Defense Authorization Act of 2008 under the FMLA may enable an employee 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 duty, and is an outpatient or on the armed services' temporary retired list.

Please keep in mind that if you do not return to work after your FMLA leave ends, you may be required to repay your employer the amount that it contributed to the Fund 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.

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. While you are on USERRA leave, you have the choice to use any remaining hours in your bank to pay for your continuation coverage or to freeze the remaining hours in your bank 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 19 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 99 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 coverage otherwise would end under the Fund.

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 determine that your failure to provide advance notice is excused, you may then elect to continue coverage and pay all amounts required to continue coverage in accordance with the COBRA election and payment procedures starting on page 20. 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. This means 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 under USERRA. 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 you have dependent coverage at the time you enter the armed services, your eligible dependents may continue coverage under the Fund by electing and making self-payments 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. According to USERRA guidelines, 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 work for a contributing employer. If your bank is frozen and you don't return to Covered Employment within the timeframes indicated, you have the right to appeal your loss of bank hours.

WHEN COVERAGE ENDS

Your eligibility for benefits may end for any of the following reasons:

- You or your covered dependents 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 8 in the ***Fraud*** section; or;
- Your dependents' coverage will end 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, whichever occurs first.

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 premiums).

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 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 114. In addition, rescissions of coverage are eligible for External Review as described starting on page 114.

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. The Continuation Coverage includes medical, hospital, prescription drug, vision care, dental and hearing benefits that are identical to the coverage you had under the Fund while an Active Employee or Retiree. Continuation coverage is not available for Life Insurance or Accidental Death and Dismemberment ("AD&D") Insurance Benefits. The Fund Office administers COBRA Continuation Coverage.

Qualifying COBRA Events

The chart below shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue. The Fund Administrator 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 16)	Your covered Dependents	18 months **
You die	Your covered Dependents	36 months ***
You divorce	Your covered former Spouse	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 the amount of the self-pay premium.

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 give notice to 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 and you do not have enough bank hours to continue your coverage (the first COBRA qualifying event), and you enroll yourself and your covered dependents for 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 terms of 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 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. The Fund Office will notify you when you have insufficient hours in the bank for coverage. Your family should notify the Fund Office in the event you die. You or your dependent must notify the Fund Office in writing within 60 days in the event 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 notified in a timely manner that one of these events has occurred, 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. The Marketplace is part of the Patient Protection and Affordable Care Act (PPACA), otherwise known as health care reform. For more information, visit **www.healthcare.gov**.

Once you receive a COBRA notice, you have 60 days from the later of the date that coverage would be lost or the date that the notice is provided in which to elect COBRA Continuation Coverage. Your covered dependents have the option of electing 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 or the dependent is 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 has to 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 covered during the 19th through the 29th months of coverage.

Your first payment must be made within 45 days after you elect to continue coverage. Your first payment for COBRA Continuation Coverage 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 to determine 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 pay part of the cost of 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 15 for more information.

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 does not pay the cost of your COBRA Continuation Coverage when it is due or within any grace period;
- The person electing coverage is widowed or divorced, subsequently remarries and is eligible for coverage under the new spouse's group health plan;
- You are continuing coverage during the 19th to 29th months of a disability and the Social Security Administration determines you are no longer disabled; or
- You or a covered dependent becomes entitled to Medicare after COBRA Continuation Coverage begins.

COBRA Claims

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

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.

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. This SPD describes the Active level of coverage.
- The **Pre-Medicare Retiree** level provides coverage to eligible Retirees and their dependents who are under age 65 and not otherwise eligible for Medicare. A Retiree is any eligible participant who is not currently eligible using bank hours, including participants eligible under the ***Continuation of Coverage During Total Disability*** section on page 8. Surviving dependents are also considered Retirees.
- 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 becomes eligible for Medicare prior to age 65. Under this coverage, covered benefits are subject to Medicare **Deductibles**, Coinsurance and determination of covered expenses.

  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. You must enroll in both Medicare Part A and Medicare Part B as soon as Medicare coverage becomes available to you. If you are eligible for Medicare, but do not enroll in both Medicare Part A and Part B, Fund benefits will be limited to secondary responsibility.

The Pre-Medicare Retiree and Medicare Supplemental Retiree levels of coverage are not described in this SPD. Please contact the Fund Office for more information about these benefits.

LIMITATIONS ON BENEFITS

The following sections describe the Hospital and Medical Benefits available under the Fund. Starting on page 114 the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

HOW THE ACTIVE LEVEL OF COVERAGE WORKS

The Fund's Hospital and medical coverage for Active Employees 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 by where you reside. If you reside in Empire's Operating Area or its contiguous counties, you will be enrolled under the POS program. If you reside outside of Empire's Operating Area, you will be enrolled under the PPO program. Both the POS and PPO Programs have identical In-Network and Out-of-Network cost sharing provisions.

<table>
<tr><th colspan="4">Empire's POS Operating Area</th></tr>
<tr><th colspan="2">New York</th><th>New Jersey</th><th>Connecticut</th></tr>
<tr>
<td>Albany
Clinton
Columbia
Delaware
Duchess
Essex
Fulton
Greene
Montgomery
Nassau
Orange
Putnam
Rensselaer
Rockland
Saratoga</td>
<td>Schenectady
Schoharie
Suffolk
Sullivan
Warren
Washington
Westchester

New York City

Bronx
Kings
Queens
New York
Richmond</td>
<td>Bergen
Hudson
Middlesex
Monmouth
Passaic
Sussex
Union</td>
<td>Fairfield
Litchfield</td>
</tr>
<tr><td colspan="4">• 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.</td></tr>
</table>

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

- **If you receive services from a Hospital.**
  - Hospitals in Empire's network or a local BlueCross BlueShield network send bills directly to Empire or the local network. The Fund will pay 90% of the Network Fees for services after you satisfy the In-Network Deductible.
  - **Non-Participating Hospitals** will 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.
- **If you see a Provider for an office visit.**
  - Providers that participate in Empire's network or a local BlueCross BlueShield 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 see a Non-Participating Provider for an office visit, the Provider may ask you to pay up front. You or the Provider will need to file a claim with Empire or the local BlueCross BlueShield 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 as well as 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 BlueCross BlueShield network will submit bills directly to Empire or the local network. The Fund will pay 90% of the Network Fee after you satisfy the In-Network Deductible
  - If you see a Non-Participating Provider, the Provider may ask you to pay up front. You or the Provider will need to file a claim with Empire or the local BlueCross BlueShield 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 as well as 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 precertify 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 800-553-9603. Empire has set timeframes 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 precertified at least two weeks ahead of time;
- An emergency admission must be certified no later than 48 hours after the Hospital admission;
- When possible, pregnancy should be precertified within three months of the beginning of the pregnancy and again within 24 hours after delivery.

Additional information concerning precertification and Empire's Medical Management Program is provided on pages 56-58.

IN-NETWORK BENEFITS AND PROCEDURES

This section summarizes your **In-Network Benefits** and Empire's procedures. You can reach Empire by phone at 800-553-9603 or on the Internet at **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 800-553-9603 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.

TRANSITIONAL CARE

Networks grow and change, and sometimes a Provider will move or leave the network. If you are an existing member 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) reimbursement at the rates applicable prior to start of transitional care, (2) adhere to the 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. Continued care is available to pregnant women who are in the second and third trimester through the delivery and postpartum period. You must contact Empire's Medical Management department to arrange this continued care.

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) 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).

If you would like 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 BlueCross BlueShield 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 62);
- 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 Medical Plan pays or seeks to impose interest or attorney's fees or other fees for late payment or non-payment, you will be 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.

How Benefits are Calculated for In-Network and Out-of-Network Care

	In-Network (Empire)	Out-of-Network
Specialist's Charge for Office Visit	$250	$250
Allowed Amount (see page 62 for an explanation of the Allowed Amount)	N/A	$200
Benefit Amount Paid	$100 (Network Fee)	$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.		

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

The Fund provides a broad range of benefits to you and your family. 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	$400/Individual $1,000/Family	$750/Individual $1,875/Family
COPAYMENT		
• **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)
CO-INSURANCE	You pay 10% of Network Fee	30% of Allowed Amount
ANNUAL OUT-OF-POCKET MAXIMUM (not including Annual Deductible)	$1,500/Individual $3,750/Family	$3,000/Individual $7,500/Family
LIFETIME MAXIMUM	Unlimited	Unlimited
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
CO-INSURANCE	You pay 10% of Network Fee	30% of Allowed Amount
SECOND OR THIRD SURGICAL OPINION	$25 per visit	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
HOME, OFFICE/OUTPATIENT CARE		
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 Network Fee 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 • **Testing & Treatment** • **Office Visit**	$20 per primary care visit or $25 per specialist visit 10% of Network Fee 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 Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
CHEMOTHERAPY, RADIATION	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
KIDNEY DIALYSIS	10% of Network Fee 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

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
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
PREVENTIVE CARE		
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**
PREVENTIVE CARE		
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 Network Fee after Deductible is satisfied	
MATERNITY CARE AND INFERTILITY TREATMENT		
PRENATAL AND POSTNATAL CARE (In doctor's office) ● Precertification required	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
MATERNITY CARE AND INFERTILITY TREATMENT		
ROUTINE NEWBORN NURSERY CARE (In Hospital)	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
OBSTETRICAL CARE (In Hospital) • Precertification required	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
OBSTETRICAL CARE (In birthing center) • Precertification required	10% of Network Fee 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 Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
ANESTHESIA AND OXYGEN	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
CHEMOTHERAPY AND RADIATION THERAPY • Precertification required	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
DIAGNOSTIC X-RAYS AND LAB TESTS	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
DRUGS AND DRESSINGS	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
GENERAL, SPECIAL AND CRITICAL NURSING CARE • Precertification required	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
INTENSIVE CARE • Precertification required	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
KIDNEY DIALYSIS • Precertification required	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL SERVICES		
SURGERY (Inpatient and 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. • Precertification required	10% of Network Fee after Deductible is satisfied	30% 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 Network Fee after Deductible is satisfied	Not covered
PROSTHETICS (e.g., artificial arms, legs, eyes, ears) • Precertification required	10% of Network Fee after Deductible is satisfied	Not covered
MEDICAL SUPPLIES (e.g., catheters, diabetic supplies, oxygen, syringes)		30% of Allowed Amount after Deductible is satisfied
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)		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 Network Fee after Deductible is satisfied	Not covered
HOSPICE • Up to 210 days per lifetime	10% of Network Fee after Deductible is satisfied	Not covered

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE (precertification required)		
HOME HEALTH CARE • Up to 200 visits per calendar year (a visit equals 4 hours of care)	10% of Network Fee after Deductible is satisfied	Not covered
HOME INFUSION THERAPY	10% of Network Fee after Deductible is satisfied	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY (precertification required)		
PHYSICAL THERAPY AND REHABILITATION • Up to 30 days of inpatient service per calendar year	10% of Network Fee 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	$25 per visit	Not covered
BEHAVIORAL HEALTH CARE (precertification required)		
Outpatient • Unlimited number of Medically Necessary visits	$20 per visit	30% of Allowed Amount after Deductible is satisfied
Inpatient • Unlimited number of Medically Necessary days • Unlimited number of Medically Necessary visits from mental healthcare professionals	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
BEHAVIORAL HEALTH CARE (precertification required)		
Outpatient ● Unlimited number of Medically Necessary visits, including visits for family counseling	10% of Network Fee after Deductible is satisfied	30% of Allowed Amount after Deductible is satisfied
Inpatient ● Unlimited number of Medically Necessary days of detoxification ● Unlimited number of Medically Necessary rehabilitation days	10% of Network Fee after Deductible is satisfied	30% 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—as long as 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 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 **Maximum Allowed Amount**.

What's Covered

Covered Services are listed in the ***Schedule of Benefits*** starting on page 29. 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 95 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 97 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 97 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. 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 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. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High blood pressure;
   - Type 2 diabetes mellitus;
   - Cholesterol; and
   - Child and adult obesity.

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations, including the well-child care immunizations as listed below:
   - DPT (diphtheria, pertussis and tetanus);
   - Polio;
   - MMR (measles, mumps and rubella);
   - Varicella (chicken pox);
   - Hepatitis B Hemophilus;
   - Tetanus-diphtheria;
   - Pneumococcal;
   - Meningococcal Tetramune; and
   - Other immunizations as required by law.

C. Preventive care and screenings 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; and

- Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry. Coverage shall be available as follows:
  - For individuals who are:
    - Ages 52 through 65: 1 baseline,
    - Age 65 and older: 1 every 2 years (if baseline before age 65 does not indicate osteoporosis), and
    - Under Age 65: 1 every 2 years (if baseline before age 65 indicates osteoporosis), and
  - For individuals who meet the criteria of the above programs, including one or more of the following:
    - Previously diagnosed with or having a family history of osteoporosis,
    - Symptoms or conditions indicative of the presence or significant risk of osteoporosis,
    - Prescribed drug regimen posing a significant risk of osteoporosis,
    - Lifestyle factors to such a degree posing a significant risk of osteoporosis, and
    - Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

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 get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. 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, including contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives;
- Breastfeeding support, supplies, and counseling are covered in full when received from a Network Provider. Benefits for breast pumps are limited to one pump per Calendar Year; and
- 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 will be covered in full when received from 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.

A list of the preventive services covered under this paragraph is available on Empire's website at **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.

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 pay a Copayment for a visit to an emergency room. 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 29 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.
  - Because it is late at night or on a weekend or holiday (and the need for treatment is not sudden and serious); and
- 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, Empire 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 Maximum 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

Empire 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 in the Local Network Area, you may receive In-Network or Out-of-Network Benefits. If you visit an In-Network doctor or urgent care center, you pay a Copayment. If you visit an Out-of-Network doctor or urgent care center, you pay a Deductible and Coinsurance.

For urgent care outside of the Local Network Area, 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 Maximum Allowed Amount. Empire'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 29. 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 timeframe. 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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 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, plans and issuers 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 your prescription drug benefits. See the ***Prescription Drug Program*** starting on page 67 for more information.

What's Not Covered

Empire 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.

If you convert to a new contract after the termination of your coverage under the Fund, the new contract may not contain these infertility benefits.

HOSPITAL SERVICES

If You Visit the Hospital

The Medical Plan 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 Maximum 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, Empire 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 29. 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.
- 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 other benefits under the Medical Plan.

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 need to 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;
- 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; and

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

- Same-Day Surgery not precertified 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 Medical Plan 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 29. 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 800-553-9603.

Disposable medical supplies, such as syringes, are covered up to the Maximum 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 29. 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 97 for contact information 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 29.

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 29. 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 six 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 29. 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 29.

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 800-553-9603.

What's Covered

Covered Services are listed in the ***Schedule of Benefits*** starting on page 29. 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 29. 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 Medical 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.

BEHAVIORAL HEALTHCARE

Your behavioral healthcare benefits cover outpatient treatment for alcohol or substance abuse both In-Network and Out-of-Network, and inpatient detoxification In-Network and Out-of-Network. Inpatient alcohol and substance abuse rehabilitation in a Facility is covered In-Network and Out-of-Network. Mental healthcare is covered on an inpatient basis In-Network and Out-of-Network and on an outpatient basis In-Network and Out-of-Network.

The Coinsurance that you pay for behavioral healthcare services will count toward reaching your annual out-of-pocket maximum.

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

Mental Health Care

What's Covered

In addition to the services listed in the ***Schedule of Benefits*** starting on page 29, the following mental health care services are covered:

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management;
- 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.

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 29, 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 Medical Plan 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, your Medical Plan 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, your Medical Plan does cover:

- Surgical removal of impacted teeth; and
- Treatment of sound natural teeth injured by accident if treated within 12 months of the Injury.

While Dental Services are excluded from the Fund's Hospital and Medical Benefits through Empire, the Fund does provide dental coverage through the Aetna DMO; see the ***Dental Benefits*** section starting on page 76 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.

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, Empire will provide benefits until the government Hospital can safely transfer the patient to a Participating Hospital.

Home Care

- Services performed at home, except for those services specifically noted elsewhere in this 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.

Miscellaneous

- Surgery and/or treatment for gender change.

Prescription Drugs

- All prescription drugs and over the counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, 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 67 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 95 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 BlueCross BlueShield 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 Medical Plan 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 Medical Plan 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 Medical Plan will pay. To help you manage your health, Empire provides Empire's Medical Management Program, a service that precertifies Hospital admissions and certain treatments and procedures, to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

Empire's Medical Management Program works with you and your Provider to help confirm the medical necessity of services and help you make sound health care decisions.

You can contact Empire's Medical Management program by calling Empire's Member Services at 800-553-9603 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 precertified with Empire's Medical Management Program.

FOR ALL HOSPITAL ADMISSIONS

- At least three 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, Psychological Testing, Intensive Outpatient Programs;
- Outpatient treatment for Mental Health Care and Substance Abuse Care;
- Occupational, physical, speech and vision therapy;
- Outpatient/Ambulatory Surgical Treatments;
- 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;
- Chiropractic care*; and
- Air ambulance.

*** Empire's Medical Management Program must be contacted to determine medical necessity of all chiropractic care after the fifth visit. Empire will not pay for any visits which Empire determines were not Medically Necessary.**

IF SERVICES ARE NOT PRECERTIFIED

If you call to precertify services as needed, 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.

INITIAL DECISIONS

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

- ***Precertification Requests***. Precertification means that Empire's Medical Management Program must be contacted for approval before you receive certain health care services that are subject to precertification. Empire will review all non-urgent requests for precertification within 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 Empire's 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 timeframes, the failure should be considered a denial. You or your doctor may immediately appeal.

IF A REQUEST IS DENIED

All denials of benefits 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 send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. (See the ***Complaints, Appeals and Grievances*** 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 Medical Plan's contract and Empire's current medical policy. Empire will then review the proposal, taking into account relevant medical literature, including current peer review 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 the member and/or 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 Medical Plan – 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 this Medical Plan 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 800-553-9603.

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 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 the Covered Individual's 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 timeframe. It is expected that you will be prepared to receive the majority of their 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

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 Maximum Allowed Amount for the Covered Service that you receive. Please see the BlueCross and BlueShield Association BlueCard Program section for additional information regarding services received outside of Empire's service area.

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

- that meet the definition of Covered Services, to the extent such services and supplies are covered under the Medical Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other applicable requirements.

You will be required to pay a portion of the Maximum 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 may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, Empire will, to the extent applicable, apply claim processing 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 Maximum 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 Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

NETWORK STATUS

The Maximum 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 Maximum 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 Maximum Allowed Amount as payment in full for that service, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible or have a Copayment 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 BlueCross and BlueShield Association rules governing claims filed by certain ancillary Providers.

For Covered Services that you receive from an Out-of-Network Provider, the Maximum Allowed Amount 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, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually.

In the event that there is no reimbursement rate used by the Centers for Medicare and Medicaid Services for Covered Services that you receive from an Out-of-Network Provider, the Maximum 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 this Medical Plan, but contracted for other plans with Empire, are also considered Out-of-Network. The Maximum Allowed Amount reimbursement 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.

For Covered Services that you receive from an Out-of-Network Hospital or Facility, the Maximum Allowed Amount will be the average amounts 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 in like kind Participating Hospitals/Facilities in the contiguous county or counties.

Unlike In-Network Providers/Hospitals/Facilities, Out-of-Network Providers/Hospitals/Facilities may send you a bill and collect for the amount of the Provider's/Hospital's/Facility's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum 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 Maximum Allowed Amount and the amount the Provider/Hospital/Facility charges. Choosing an In-Network Provider/Hospital/Facility will likely result in lower out-of-pocket costs to you. 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 also available to assist you in determining the Maximum 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 code(s) and diagnosis code(s) for the services at issue. You will also need to know 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 Maximum Allowed Amount for your claim will be based on the actual claim submitted.

YOUR COST SHARE

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

Your cost share amount and 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 Medical Plan's benefits or cost share amounts may vary by the type of Provider you use.

Empire will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services regardless of whether such services are performed by an In-Network Provider or an Out-of-Network Provider. Both services specifically excluded by the terms of the Medical Plan 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 as In-Network only in this SPD.

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 Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only. Please see Schedule of Benefits for your applicable amounts.

Example: Your Medical Plan has Coinsurance of 20% for In-Network services, and 30% Out-of-Network after the In- or Out-of-Network Deductible has been met. You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

The Out-of-Network anesthesiologist's charge for the service is $1,200. The Maximum Allowed Amount for the anesthesiology service is $950; your Coinsurance responsibility is 20% of $950, or $190; and the remaining allowance from Empire is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1,200 and $950. Provided the Deductible has been met, your total out of pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.

You choose an In-Network surgeon. The charge is $2,500. The Maximum Allowed Amount for the surgery is $1,500; your Coinsurance when an In-Network surgeon is used is 20% of $1,500, or $300. Empire pays 80% of $1,500, or $1,200. The In-Network surgeon accepts the total of $1,500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.

You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2,500. The Maximum Allowed Amount for the surgery is $1,500; your Coinsurance for the Out-of-Network surgeon is 30% of $1,500, or $450 after the Out-of-Network Deductible has been met. Empire pays the remaining 70% of $1,500, or $1,050. In addition, the Out-of-Network surgeon may bill you the difference between $2,500 and $1,500, so your total out of pocket charge would be $450 plus an additional $1,000, for a total of $1,450.

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 Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for information or to request authorization.

The following are examples for illustrative purposes only. Please see Schedule of Benefits chart for your applicable amounts.

Example: You require the services of a specialist; but there is no In-Network Provider for that specialty in your state of residence. You contact Empire in advance of receiving any Covered Services, and Empire authorizes you to go to an available Out-of-Network Provider for that Covered Service and agree that the In-Network cost share will apply.

Your Medical Plan has a 30% Coinsurance for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because Empire has authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and Empire will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325.

PRESCRIPTION DRUG PROGRAM

HOW THE PRESCRIPTION DRUG PLAN WORKS

The Prescription Drug Plan 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.

Express Scripts administers the Fund's prescription drug program and maintains the pharmacy network. The network currently includes K-Mart, 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, you must pay the full cost when you pick up the prescription and then file a claim for reimbursement with Express Scripts. The Prescription Drug Plan 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. Claim forms are available from Express Scripts.

You will receive an ID card when your coverage starts. The following table summarizes these benefits.

Type of Drug	Retail *Up to a 34-day supply*	Mail Order *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.

LIMITATIONS ON BENEFITS

The following sections describe the Prescription Drug Program Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

PREVENTIVE MEDICATIONS COVERED AT 100%

The Prescription Drug Plan 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 go to **www.express-scripts.com** or call Express Scripts Member Services at 800-939-2091.

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

- Iron Supplements from 6 months of age through 12 months of age;
- Fluoride Supplements from 6 months of age through five years of age;
- Aspirin for men from age 45 through age 79;
- Aspirin for women from age 55 through age 79;
- Folic Acid;
- Smoking Cessation Products;
- Contraceptives for women through age 50; and
- Preventive medications for breast cancer for women age 35 and older, including Tamoxifen (generic), Raloxifene (generic), and Soltamox (Tamoxifen liquid) (brand).

ADDITIONAL COPAYMENT FOR BRAND-NAME DRUGS WITH GENERIC EQUIVALENTS

You pay a lower Copayment for preferred brand-name and generic drugs. These medications help keep the cost of your prescription plan affordable. Non-preferred brands will cost you and the Prescription Drug Plan 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. This feature will also apply whether or not your physician writes the prescription as "Dispense as Written" (DAW). If your physician believes you must take the brand-name drug for medical reasons, please ask your physician to request a review by contacting Express Scripts at 800-753-2851.

MANDATORY MAIL-ORDER PROGRAM

If you take a medication on a long-term or continuous basis, you must 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 may not refill the prescription again through a retail pharmacy. You must then 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 34-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**.

PRE-AUTHORIZATION

You must obtain pre-authorization 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. 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. Please be aware that 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)

Examples of Prescription Drugs that Require Pre-Authorization:	
Drug Category	**Drug Name**
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)

Examples of Prescription Drugs that Require Pre-Authorization:	
Drug Category	**Drug Name**
RHEUMATOLOGICAL AGENTS	**Actemra** (tocilizumab) **Arava** (leflunomide) **Cimzia** (Certolizumab pegol) **Enbrel** (etanercept) **Humira** (adalimumab) **Kineret** (anakinra) **Orencia** (abatacept) **Remicade** (infliximab) **Rituxan** (rituximab) **Simponi** (golimumab)
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 (repostory corticotropin injection)**
OPIOD 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)

STEP THERAPY FOR PROTON PUMP INHIBITOR THERAPY AND OXYCONTIN

Proton pump inhibitor drugs ("PPIs") are used to treat certain stomach conditions, and the Prescription Drug Plan's coverage of PPIs has special rules to better control costs and ensure appropriate treatment. Specifically, Aciphex®, Dexilant™, lansoprazole, Prevacid®, Prilosec® Packets, Protonix® suspension, Zegerid®, and omeprazole/sodium bicarbonate (generic for Zegerid) are not covered unless you first get approval through a coverage review. The PPI medications omeprazole, pantoprazole, and Nexium® will continue to be covered without a review. You'll pay only the Copayment when filling these prescriptions.

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 and do not first obtain 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 using your current medication, he/she can request a coverage review by calling 800-417-1764, 8:00 a.m. to 9:00 p.m., Eastern Time.

COVERAGE LIMITATIONS

For most prescription drugs, the Prescription Drug Plan provides coverage in quantities up to a 34-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. Please be aware that 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

Examples of Prescription Drugs with Quantity Limitations and/or Coverage Requirements:		
Drug Category	**Drug Name**	**Quantity Limitation or Coverage Requirement**
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 34-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 approved by the FDA 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.

DENTAL BENEFITS

HOW THE DENTAL PLAN WORKS

The Dental Plan provides dental coverage and benefits through an insured arrangement with the Aetna Life Insurance Company ("Aetna"). Most participants are enrolled in the Dental Maintenance Organization (DMO) Plan. Participants who reside outside the service area of the DMO are enrolled in the Comprehensive Dental Plan.

You will be notified automatically when your coverage begins if you are being enrolled in the Comprehensive Dental Plan. Information concerning the Comprehensive Dental Plan begins on page 84. If you are not notified otherwise, you are enrolled in the DMO Plan.

More detailed information about both the DMO Plan and the Comprehensive Dental Plan can be found by visiting www.aetna.com and registering as a user. Once you register as a user, you will have access to the secure Aetna Navigator web site.

LIMITATIONS ON BENEFITS

The following sections describe the Dental Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

THE DMO PLAN

The DMO Plan requires that you access all care through a primary care dentist (PCD). You and each eligible member of your family select a PCD when your coverage begins. You will not be able to access dental care until you select a PCD. Your PCD provides basic and routine dental services and supplies and, if necessary, will refer you to specialist dental Providers in the DMO network. You must have a referral from your PCD in order to receive coverage for services provided by any dentist in the DMO network other than your PCD.

If you are enrolled in the DMO Plan, Out-of-Network Services and supplies are not covered except in the event of a dental emergency.

SELECTING A PCD

Once you are eligible, you may contact Aetna customer service at 855-201-8436 for help selecting a PCD. You can also select a PCD online. Visit www.aetna.com and follow the instructions to register. Once you have created a user name and password, you may select a PCD on the secure Aetna Navigator web site. Your eligible family members must also select a PCD. All family members may have the same PCD or each family member may select their own PCD.

If you become eligible and you and your family members have not selected a PCD, you will receive an identification card that lists each family member and the notation "NOT SELECTED" next to each of their names. You cannot schedule an appointment until you select a PCD. Once you and your family members select a PCD, the identification card will be reissued with the PCD selected listed next to each family member's name. You may then schedule an appointment.

CHANGING YOUR PCD

You may change your PCD at any time on Aetna's website, **www.aetna.com**, or by writing to Aetna or by calling Aetna Member Services at (855) 201-8436. Changes to your PCD will be effective as follows:

- If Aetna receives a request on or before the 15th day of the month, the change will be effective on the first day of the next month; or
- If Aetna receives a request after the 15th day of the month, the change will be effective on the first day of the month following the next month.

AVAILABILITY OF PROVIDERS

Aetna cannot guarantee the availability or continued participation of DMO Plan Providers. Either Aetna or a network Provider may terminate the Provider contract or limit the number of patients accepted in a practice. If the PCD initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between Aetna and your selected PCD is terminated, Aetna will notify you of the termination and request that you select another PCD.

THE REFERRAL PROCESS

There may be times when you need services and supplies that only a dental specialist can provide. In these cases, your PCD will make a referral to a specialist dentist. A PCD referral is not required for Orthodontic services.

Having a referral from your PCD keeps your out-of-pocket expenses lower for services of a specialist dentist and any necessary follow-up treatment. The referral is important because it is how your PCD arranges for you to receive care and follow-up treatment.

You must have a referral from your PCD in order to receive the DMO Plan level of coverage for any services received from a specialist dentist.

HOW REFERRALS WORK

When your PCD determines that your treatment should be provided by a specialist dentist, you'll receive a written or electronic referral. The referral will be good for 90 days, as long as you remain covered under the DMO Plan.

Review the referral with your PCD. Make sure you understand what types of services have been recommended and why.

When you visit the specialist dentist, bring the referral (or check in advance to verify that the specialist has received the electronic referral). You cannot request a referral from your PCD after you have received services from a specialist dentist.

If a service you need isn't available from a network Provider, your PCD may refer you to an Out-of-Network Provider. Your PCD must get precertification from Aetna and issue a special Out-of-Network referral for services from Out-of-Network Providers to be covered at the DMO Plan level of coverage.

WHEN YOU DO NOT NEED A PCD REFERRAL

You do ***not*** need a PCD referral for:

- Emergency care (please refer to the In the Case of a Dental Emergency section); and
- Orthodontic services and supplies.

IN CASE OF A DENTAL EMERGENCY

If you need dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. A dental emergency is any dental condition which:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

If you have a dental emergency, call your PCD. If you cannot reach your PCD or are away from home, you may get treatment from any dentist. You may also call Aetna Member Services at (855) 201-8436 for help finding a dentist. The care you receive must be for the temporary relief of the dental emergency until you can be seen by your PCD. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given.

The DMO Plan pays a benefit up to the dental emergency maximum of $100. All follow-up care should be provided by your PCD.

If you receive care from an Out-of-Network Provider for a non-emergency dental condition (that is, one that does not meet the definition above), no benefits will be payable.

WHAT YOU PAY FOR DMO PLAN SERVICES

The sections that follow explain what you pay for covered dental services and what dental services and supplies are covered by the DMO Plan.

The ***Schedule of DMO Benefits*** lists the amounts you pay for covered dental services and supplies. The amount you pay is indicated as either a percentage of the dentist's usual charge or, in the case of Orthodontics, as a fixed Copayment. Your PCD will provide you with a copy of the usual fee schedule if you request it. Please keep in mind that the usual fee schedule is used only to calculate the amount you must pay the dentist. The usual fee schedule is not used as a basis to compensate DMO Plan Providers.

The ***DMO Dental Care Schedule*** lists the dental services and supplies that are covered under the DMO Plan. If a dental service or supply is not listed in the ***DMO Dental Care Schedule***, it is not covered by the DMO Plan.

Please note that the ***Schedule of DMO Benefits*** and the ***DMO Dental Care Schedule*** refer to four types of expenses; Type A, Type B, Type C, and Orthodontic. Each covered dental service and supply is categorized into one of the four types above. To find your Copayment for a particular dental service, find the service in the ***DMO Dental Care Schedule***, note the category of expense it is (Type A, Type B, Type C or Orthodontic) and find the Copayment for that type of expense in the ***Schedule of DMO Benefits***.

SCHEDULE OF DMO BENEFITS

Service Type	Your Copayment
Type A Expenses	0%
Type B Expenses	0%
Type C Expenses	20%
Orthodontic Expenses (Fixed Copay)	
Orthodontic screening exam	$30
Orthodontic diagnostic records	$150
Comprehensive orthodontic treatment of adult or adolescent dentition	$745
Orthodontic retention	$275
Orthodontic Lifetime Maximum	24 months of active treatment plus 24 months active retention
Dental Emergency Maximum	The DMO Plan will pay no more than $100 in the event of a dental emergency

DMO DENTAL CARE SCHEDULE

This Dental Care Schedule applies to Covered Services and supplies provided by Primary Care Dentists and other network Providers upon referral from your PCD. The DMO Plan covers only the services and supplies in the list below.

Type A Expenses

- **Visits and Exams**
  - Office visit for oral exam (limited to 4 visits per year)
  - Emergency palliative treatment
  - Prophylaxis (cleaning) (limited to 2 treatments per year)
    - Adult
    - Child
  - Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)
  - Oral hygiene instruction

- Sealants, per tooth (limited to 1 application every 3 years for permanent molars only, and to covered persons under age 16)
- Pulp vitality test
- Diagnostic casts

- **X-Rays and Pathology**
  - Bitewing X-rays (limited to 1 set per year)
  - Entire series, including bitewings, or panoramic films (limited to 1 set every 3 years)
  - Vertical bitewing X-rays (limited to 1 set every 3 years)
  - Periapical X-rays
  - Intra-oral, occlusal view, maxillary, or mandibular
  - Extra-oral upper or lower jaw
  - Biopsy and histopathologic examination of oral tissue
- **Space Maintainers**. Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
  - Fixed, band type
  - Removable acrylic with round wire clasp

Type B Expenses

- **Endodontics** (Includes local anesthetics where necessary)
  - Pulp capping
  - Pulpotomy
  - Surgical exposure for rubber dam isolation
  - Root canal therapy, including necessary X-rays
    - Anterior
    - Bicuspid
  - Apexification/recalification
  - Apicoectomy (per tooth) - first root
  - Apicoectomy (per tooth) - each additional root
  - Retrograde Filling
  - Root Amputation
  - Hemisection
- **Restoration and Repair**
  - Amalgam restoration
    - 1 surface
    - 2 surfaces
    - 3 or more surfaces
  - Resin restoration (other than for molars)
    - 1 surface
    - 2 surfaces
    - 3 or more surfaces or incisal angle
  - Retention pins
  - Sedative fillings
  - Stainless steel crowns
  - Prefabricated resin crowns (excluding temporary crowns)
  - Recementing inlays, crowns, bridges, space maintainers
  - Tissue conditioning for dentures

- **Periodontics**
  - Scaling and root planing - per quadrant (limited to 4 separate quadrants, every 2 years)
  - Scaling and root planing - 1 to 3 teeth, per quadrant (limited to once per site, every 2 years)
  - Periodontal maintenance procedures following surgical therapy (limited to 2 per year)
  - Gingivectomy or gingivoplasty - per quadrant (limited to 1 per quadrant every 3 years)
  - Gingivectomy or gingivoplasty - 1 to 3 teeth (limited to 1 per site, every 3 years)
  - Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
  - Gingival flap procedure - 1 to 3 teeth per quadrant (limited to 1 per site, every 3 years)
  - Occlusal adjustment (other than with an appliance or by restoration)
- **Oral Surgery** (Includes local anesthetics where necessary and routine post-operative care)
  - Extractions, erupted tooth or exposed root
  - Extractions, coronal remnants
  - Surgical removal of erupted tooth
  - Surgical removal of impacted tooth (soft tissues)
  - Excision of hyperplastic tissue
  - Excision of pericoronal gingiva
  - Incision and drainage of abscess
  - Crown exposure to aid eruption
  - Removal of foreign body from soft issue
  - Suture of soft tissue Injury
  - Removal of residual root
  - Removal of odontogenic cyst
  - Closure of oral fistula
  - Removal of foreign body from bone
  - Sequestrectomy
  - Frenectomy
  - Transplantation of tooth or tooth bud
  - Alveoplasty in conjunction with extractions - per quadrant
  - Alveoplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty not in conjunction with extractions - per quadrant
  - Alveoplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Removal of exostosis
  - Sialolithotomy; removal of salivary calculus
  - Closure of salivary fistula

Type C Expenses

- **Restorations**
  - Inlays
    - 1 surface
    - 2 surfaces
    - 3 or more surfaces

- Onlays
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Crowns (including build-ups when necessary)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
  - Post and core
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal

- **Dentures and Partials** (includes relines, rebases, and adjustments within 6 months after installation)
  - Full (upper and lower)
  - Partial
  - Stress breakers (per unit)
  - Interim partial denture (stayplate), anterior only
  - Crown and bridge repairs
  - Adding teeth to an existing denture
  - Full and partial denture repairs
  - Relining/rebasing dentures (including adjustments within six months after installation)
  - Occlusal guard (for bruxism only) limited to 1 every 3 years
- **Endodontics** (Includes local anesthetic where necessary)
  - Molar root canal therapy, including necessary X-rays
- **Intravenous Sedations and General Anesthesia**
- **Oral Surgery** (Includes local anesthetics where necessary and post-operative care)
  - Surgical removal of impacted teeth
    - Partially bony
    - Completely bony
    - Completely bony with unusual surgical implications
- **Periodontics**
  - Osseous surgery (including flap entry and closure), per quadrant, limited to 1 per quadrant, every 3 years
  - Osseous surgery (including flap entry and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years

- Soft tissue graft procedure
- Clinical crown lengthening - hard tissue

- **Orthodontic Expenses**
  - Orthodontic screening exam
  - Orthodontic diagnostic records
  - Comprehensive orthodontic treatment of adult or adolescent dentition
  - Orthodontic retention

ALTERNATE TREATMENT RULE

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. For example, you may request that a non-covered service be performed when there is an alternate covered service available. Or, more than one covered service may be available to treat your condition.

When alternate services or supplies can be used, the DMO Plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

Of course, you and your dental Provider can still choose the more costly treatment method. Your dentist will discuss all optional treatment plans with you in advance and fully advise you of all additional fees for which you will be responsible. You will be asked to sign a Patient Financial Informed Consent form or an equivalent document prior to beginning treatment in order to document your understanding of your financial responsibility in Alternate Treatment situations. **If the covered benefits, options and fees are not discussed with you in advance and agreed to in writing, you may not be billed for any additional charges beyond the normal Copayment for the covered service.**

WHAT HAPPENS WHEN THERE ARE NO PRIMARY CARE DENTISTS IN YOUR REGION – THE COMPREHENSIVE DENTAL PLAN

The DMO Plan requires that you use the Aetna DMO network and coordinate all care with your selected PCD. While the Aetna DMO network is large, PCDs are not accessible in all regions. The Fund has determined beforehand what regions do not have sufficient PCDs. If you reside in one of these regions, you will be notified when your coverage begins that you are being enrolled in the Aetna Comprehensive Dental Plan. The Comprehensive Dental Plan does not require you to select a PCD. When you are enrolled in the Comprehensive Dental Plan, you can receive Covered Services and supplies from any dentist you choose.

ENROLLING IN THE DMO IF YOU LIVE OUTSIDE THE SERVICE AREA

If you receive notice when your coverage begins that you are being enrolled in the Comprehensive Dental Plan but you want to enroll in the DMO Plan instead, you have two weeks from the date of the notice to enroll in the DMO Plan. If you do not enroll in the DMO Plan within two weeks of the date of the notice, you will only be permitted to change from the Comprehensive Dental Plan to the DMO Plan between

January 1 and January 15 each year. You must call Aetna at 855-201-8436 to enroll in the DMO Plan if you live outside the service area.

If you live within the service area of the DMO Plan, you may not change to the Comprehensive Dental Plan.

WHAT YOU PAY FOR COMPREHENSIVE DENTAL PLAN SERVICES

There are important differences between the Comprehensive Dental Plan and the DMO Plan. The Comprehensive Plan has Deductibles, an annual maximum and different cost sharing amounts than the DMO Plan. In general, you will have greater out-of-pocket expenses under the Comprehensive Dental Plan than you would under the DMO Plan. Most significantly, you are responsible for paying the dentist's full charge under the Comprehensive Dental Plan.

Comprehensive Dental Plan payments are based upon Aetna's determination of the "recognized charge" for a dental service or supply. The recognized charge is the lesser of:

- What the Provider bills for the service or supply; or
- The 80th percentile of the Prevailing Charge Rate for the Geographic Area where the service is furnished.

In the event Aetna has an agreement with a Provider that sets the rate that Aetna will pay for a dental service or supply, then the recognized charge is the rate established in such an agreement. Aetna may also reduce the recognized charge by applying its own Reimbursement Policies, which are based upon generally accepted standards of dental practice.

Your out-of-pocket expense under the Comprehensive Dental Plan includes:

- Charges applied towards your Deductible,
- Your coinsurance, and
- The difference between the dentist's full charge and Aetna's recognized charge.

You can find the Comprehensive Dental Plan Deductibles, coinsurance and maximums in the ***Schedule of Comprehensive Dental Plan Benefits*** that follows.

OBTAINING AN ADVANCE CLAIM REVIEW

The purpose of the advance claim review is to determine, in advance, the benefits the Comprehensive Dental Plan will pay for proposed services. Knowing ahead of time which services are covered by the Comprehensive Dental Plan, and the benefit amount payable, helps you and your dentist make informed decisions about the care you are considering.

The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

WHEN TO OBTAIN AN ADVANCE CLAIM REVIEW

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Ask your dentist to prepare a full written description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna. Aetna may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the Comprehensive Dental Plan. You and your dentist can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See ***Benefits When Alternate Procedures Are Available*** for more information on alternate dental procedures.)

The ***Schedule of Comprehensive Dental Plan Benefits*** lists the Deductibles, the annual and lifetime maximums, and what the Comprehensive Dental Plan pays for covered dental services and supplies. The amount the Comprehensive Dental Plan pays is indicated as a percentage of Aetna's recognized charge.

The ***Comprehensive Dental Plan Schedule of Care*** lists the dental services and supplies that are covered under the Comprehensive Dental Benefits Plan. If a dental service or supply is not listed in the ***Comprehensive Dental Plan Schedule of Care***, it is not covered by the Comprehensive Dental Plan.

Please note that the ***Schedule of Comprehensive Dental Plan Benefits*** and the ***Comprehensive Dental Plan Schedule of Care*** refer to four types of expenses; Type A, Type B, Type C, and Orthodontic. Each covered dental service and supply is categorized into one of the four types above. To find your Copayment for a particular dental service, find the service in the ***Comprehensive Dental Plan Schedule of Care***, note the category of expense it is (Type A, Type B, Type C or Orthodontic) and find the Copayment for that type of expense in the ***Schedule of Comprehensive Dental Plan Benefits***.

SCHEDULE OF COMPREHENSIVE DENTAL PLAN BENEFITS

- **Calendar Year Deductible**
  - $50 per Individual
  - $150 per Family (three covered persons must fully meet their individual Deductible for the family Deductible to apply)
  - The Calendar Year Deductible applies to all covered expenses except Type A Expenses.
- **Comprehensive Dental Plan Coinsurance** (This is the percentage of Aetna's recognized charge that the Comprehensive Dental Plan pays after the Deductible is satisfied. Once applicable Deductibles have been met, the Comprehensive Dental Plan will pay a percentage of the covered expenses, and

you will be responsible for the rest of the costs. The coinsurance percentage varies by the type of expense.)

- Type A Expenses: 100%
- Type B Expenses: 100%
- Type C Expenses: 50%
- Orthodontic Treatment: 50%

- **Calendar Year Maximum Benefit: $2500**
- **Orthodontic Treatment**
  - Orthodontic Lifetime Maximum Benefit: $1,000 (The most the Comprehensive Dental Plan will pay for covered expenses incurred by any one covered person is called the orthodontic lifetime maximum benefit.)

COMPREHENSIVE DENTAL PLAN SCHEDULE OF CARE

Type A Expenses: Diagnostic and Preventive Care

- **Visits and X-Rays**
  - Office visit during regular office hours, for oral examination
    - Routine comprehensive or recall examination (limited to 2 visits every year)
    - Problem-focused examination (limited to 2 visits every year)
  - Prophylaxis (cleaning) (limited to 2 treatments per year)
    - Adult
    - Child
  - Topical application of fluoride (limited to one course of treatment per year and to Children under age 16)
  - Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to Children under age 16)
  - Bitewing X-rays (limited to 1 set per year)
  - Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
  - Vertical bitewing X-rays (limited to 1 set every 3 years)
  - Periapical x-rays (single films up to 13 films)
- **Space Maintainers**. Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
  - Fixed (unilateral or bilateral)
  - Removable (unilateral or bilateral)

Type B Expenses: Basic Restorative Care

- **Visits and X-Rays**
  - Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
  - Emergency palliative treatment, per visit
- **X-Ray and Pathology**
  - Intra-oral, occlusal view, maxillary or mandibular
  - Upper or lower jaw, extra-oral
  - Biopsy and histopathologic examination of oral tissue

- **Oral Surgery**
  - Extractions
    - Erupted tooth or exposed root
    - Coronal remnants
    - Surgical removal of erupted tooth/root tip
  - Impacted Teeth
    - Removal of tooth (soft tissue)
  - Odontogenic Cysts and Neoplasms
    - Incision and drainage of abscess
    - Removal of odontogenic cyst or tumor
  - Other Surgical Procedures
    - Alveoplasty, in conjunction with extractions - per quadrant
    - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
    - Alveoplasty, not in conjunction with extraction - per quadrant
    - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
    - Sialolithotomy: removal of salivary calculus
    - Closure of salivary fistula
    - Excision of hyperplastic tissue
    - Removal of exostosis
    - Transplantation of tooth or tooth bud
    - Closure of oral fistula of maxillary sinus
    - Sequestrectomy
    - Crown exposure to aid eruption
    - Removal of foreign body from soft tissue
    - Frenectomy
    - Suture of soft tissue Injury
- **Periodontics**
  - Occlusal adjustment (other than with an appliance or by restoration)
  - Root planning and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
  - Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
  - Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
  - Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years
  - Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
  - Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
  - Periodontal maintenance procedures following active therapy (limited to 2 per year)
  - Localized delivery of antimicrobial agents
- **Endodontics**
  - Pulp capping
  - Pulpotomy
  - Apexification/recalcification
  - Apicoectomy
  - Root canal therapy including necessary X-rays
    - Anterior
    - Bicuspid

- **Restorative Dentistry**. Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
  - Amalgam restorations
  - Resin-based composite restorations (other than for molars)
  - Pins
    - Pin retention—per tooth, in addition to amalgam or resin restoration
  - Crowns (when tooth cannot be restored with a filling material)
    - Prefabricated stainless steel
    - Prefabricated resin crown (excluding temporary crowns)
  - Recementation
    - Inlay
    - Crown
    - Bridge

Type C Expenses: Major Restorative Care

- **Oral Surgery**
  - Surgical removal of impacted teeth
    - Removal of tooth (partially bony)
    - Removal of tooth (completely bony)
- **Periodontics**
  - Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years
  - Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years
  - Soft tissue graft procedures
  - Clinical crown lengthening, hard tissue
  - Full mouth debridement, once per lifetime
- **Endodontics**
  - Root canal therapy including necessary X-rays
  - Molar
- **Restorative**. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic Injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years- see ***Replacement Rule***).
  - Inlays/Onlays
  - Labial Veneers
    - Laminate-chairside
    - Resin laminate – laboratory
    - Porcelain laminate – laboratory
  - Crowns
    - Resin
    - Resin with noble metal
    - Resin with base metal
    - Porcelain/ceramic substrate
    - Porcelain with noble metal
    - Porcelain with base metal
    - Base metal (full cast)

  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
- Post and core
- Core build up, including any pins

- **Prosthodontics-** First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See ***Tooth Missing But Not Replaced Rule***.) Replacement of existing bridges or dentures is limited to 1 every 8 years. (See ***Replacement Rule***.)
  - Bridge Abutments (See Inlays and Crowns)
  - Pontics
    - Base metal (full cast)
    - Noble metal (full cast)
    - Porcelain with noble metal
    - Porcelain with base metal
    - Resin with noble metal
    - Resin with base metal
  - Removable Bridge (unilateral)
    - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
  - Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
    - Complete upper denture
    - Complete lower denture
    - Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
    - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Stress breakers
    - Interim partial denture (stayplate), anterior only
    - Office reline
    - Laboratory reline
    - Special tissue conditioning, per denture
    - Rebase, per denture
    - Adjustment to denture more than 6 months after installation
  - Full and partial denture repairs
    - Broken dentures, no teeth involved
    - Repair cast framework
    - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
  - Repairs: crowns and bridges
  - Occlusal guard (for bruxism only), limited to 1 every 3 years
- **General Anesthesia and Intravenous Sedation** (only when Medically Necessary and only when provided in conjunction with a covered surgical procedure)

- **Orthodontics**
  - Interceptive orthodontic treatment
  - Limited orthodontic treatment
  - Comprehensive orthodontic treatment of adolescent dentition
  - Comprehensive orthodontic treatment of adult dentition
  - Post treatment stabilization
  - Removable appliance therapy to control harmful habits
  - Fixed appliance therapy to control harmful habits

RULES AND LIMITS THAT APPLY TO BOTH THE DMO PLAN AND TO THE COMPREHENSIVE DENTAL PLAN

Several rules apply to the Dental Plan. Following these rules will help you use the Dental Plan to your advantage by avoiding expenses that are not covered by the Dental Plan.

ORTHODONTIC TREATMENT RULE

The Dental Plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of micrognathia,
- Treatment of cleft palate;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

The Dental Plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the Dental Plan.

REPLACEMENT RULE

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the Dental Plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- While you were covered by the Dental Plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge;

- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable; and
- You had a tooth (or teeth) extracted while you were covered by the Dental Plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

TOOTH MISSING BUT NOT REPLACED RULE

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the Dental Plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

ALTERNATE TREATMENT RULE

If you are enrolled in the DMO Plan, please refer to the Alternate Treatment Rule section on page 83.

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Dental Plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental Provider. Of course, you and your dental Provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the Dental Plan will cover.

COVERAGE FOR DENTAL WORK BEGUN BEFORE YOU ARE COVERED BY THE DENTAL PLAN

The Dental Plan does not cover dental work that began before you were covered by the Dental Plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the Dental Plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the Dental Plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the Dental Plan.

COVERAGE FOR DENTAL WORK COMPLETED AFTER TERMINATION OF COVERAGE

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The Dental Plan does not cover dental services that are given after your coverage terminates, subject to the following exception. The Dental Plan will cover the following services if they are ordered while you were covered by the Plan, and installed within 30 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

WHAT THE DMO AND THE COMPREHENSIVE DENTAL PLAN DO NOT COVER

Not every dental care service or supply is covered, even if prescribed, recommended, or approved by your physician or dentist. The Dental Plan covers only those services and supplies that are Medically Necessary and included in either the ***DMO Dental Care Schedule*** or the ***Comprehensive Dental Plan Care Schedule*** depending upon the plan you are enrolled in. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or that are subject to special limitations.

- Any instruction for diet, plaque control and oral hygiene;
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the What the Dental Plan Covers section. Facings on molar crowns and pontics will always be considered cosmetic. But this exclusion will not apply to dental care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident, or to dental care or treatment necessary due to a congenital disease or anomaly;
- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic Injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge;

- Dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants;
- Dental services and supplies that are covered in whole or in part:
  - Under any other part of this Dental Plan; or
  - Under any other plan of group benefits provided by the Welfare Fund;
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion;
- Except as covered in the What the Dental Plan Covers section, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment;
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply;
- Orthodontic treatment except as noted in the Dental Care Schedules;
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium);
- Prescribed drugs; pre-medication; or analgesia;
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures;
- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services;
- Services and supplies provided by an Out-of-Network Provider unless you are enrolled in the Comprehensive Dental Plan;
- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a Provider;
- Services and supplies provided in connection with treatment or care that is not covered under the Dental Plan;
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth;
- Surgical removal of impacted wisdom teeth only for orthodontic reasons; and
- Treatment by other than a dentist. However, the Plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  - Scaling of teeth, and
  - Cleaning of teeth.

RESERVE TRIGGER POINT

In order to timely respond to any deterioration in the Fund's financial condition, dental and vision 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, dental and vision benefits will be rescinded and only restored when the assets return to another predetermined level. Specifically, if reserves drop below seven months, dental and vision benefits will be rescinded on the first day of the next month. However, if reserves then increase to nine months, such benefits will be restored on the first day of the following month.

VISION CARE BENEFITS

HOW THE VISION CARE PLAN WORKS

Vision Care 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 of these networks for your vision services, 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.

LIMITATIONS ON BENEFITS

The following sections describe the Vision Care Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

BENEFITS

If you are eligible for Vision Care Benefits, you and your covered dependents are entitled to an eye examination and new glasses or contact lenses once every 12 months. If you use 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 receive a credit towards your purchase.

Retirees residing abroad. The Vision Care Plan does not provide vision coverage for Retirees residing outside the United States.

COVERED SERVICES

The Fund pays a Participating Provider a total of $125; in general, $25 for an exam and $100 for a pair of frames and/or lenses. If you use a Non-Participating Provider, the Fund will reimburse you up to $125 for the same package of services. You can obtain a list of Participating Providers from the Fund Office at 800-529-3863.

COSTS

Some services that you receive from Participating Providers require that you pay a portion of the cost. These services and their costs are listed below. If you receive any of these services on an Out-of-Network basis, 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	$70	$70
Polycarbonate bifocal lenses	$100	$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. All you have to do is provide your name and Social Security 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 use a Provider who is not in the CPS or GVS network, you must pay the full fee and submit a claim to the Fund Office for reimbursement. The Fund will pay only the amount it would have paid had you gone to a Participating Provider (up to $125 for an exam and a pair of frames and lenses).

See the ***Claims, Claims Review and Appeals Procedures*** section starting on page 114 for additional information on filing claims, and for procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

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 rescinded and only restored when the assets return to another predetermined level. Specifically, if reserves drop below seven months, vision and dental benefits will be rescinded on the first day of the next month. However, if reserves then increase to nine months, such benefits will be restored on the first day of the following month.

HEARING BENEFITS

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

LIMITATIONS ON BENEFITS

The following sections describe the Hearing Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

COVERED SERVICES

You may obtain benefits at any Provider with whom GVS and CPS have negotiated special discounts on your behalf. For a listing of Participating Providers, call: GVS at 800-847-4661 or CPS at 212-675-5745. Coverage is provided at no cost to you at a CPS Provider and for a $145 Copayment at a GVS Provider for the following:

- A hearing evaluation;
- A behind-the-ear, in-the-ear or otosonic hearing aid, or any comparable manufacturer's hearing aid;
- A battery for your hearing aid, with a one-year guarantee; and
- Unlimited services of your hearing aid for one year.

If you select a hearing aid that is not part of the Fund package, you may have to make additional payments.

When you go to a Non-Participating Provider, you will have to pay for the services you receive and submit a claim to the Fund Office. The Fund will reimburse you the same amount it would have paid if you had gone to a Network Provider, up to a maximum benefit of $350 for each ear, one every four years. The benefit is available to all eligible family members.

HOW TO FILE A CLAIM

Network Provider. All you have to do is 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 use a Provider that is not in the CPS or GVS 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 own records.

In the ***Claims and Appeals Procedures*** section, there's additional information on filing claims, and the procedures to follow in appealing a claim that is wholly or partially denied.

COORDINATION OF BENEFITS

You or members of your family may have other health care coverage. In this case, the two health coverage programs will coordinate their benefit payments so that payments from the two plans combined 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 both 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 parent with custody is primary.
- If the parent with custody is remarried, his/her plan pays first, then the step-parent's plan pays second and the non-custodial parent 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 THIS BENEFIT PLAN IS THE SECONDARY PLAN

If this Benefit Plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, this Benefit Plan will not 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. Remember to keep a copy for your records.
- You are required to provide information about other health care coverage you or members of your family may have whenever the Fund Office or one of the Benefit Plan's claims administrators requests it. Should 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 should 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.

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 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

HOW THE LIFE INSURANCE PLAN 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 coverage will continue in the amount of $8,000.

If you are an eligible Active Employee or 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 as of the end of the month in which you die.

Note for 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 elect to pay the full Retiree premium.

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). Please keep in mind 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, 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.

ACCELERATED DEATH BENEFIT

If you're an Active Employee, you may elect to have an Accelerated Benefit amount 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 still 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 paid 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 Continuation of Coverage During Total Disability as described in the section on eligibility and participation (see page 8). 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 insurance company directly.

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. In addition, you will not 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. 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.

In the ***Claims and Appeals Procedures*** section, there's 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

HOW THE ACCIDENTAL DEATH AND DISMEMBERMENT PLAN WORKS

The Accidental Death and Dismemberment (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 your 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 amount that can be paid under the AD&D plan 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.

LIMITATIONS ON BENEFITS

The following sections describe the Accidental Death and Dismemberment Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

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 102.

EXCLUSIONS

The Accidental Death and Dismemberment Plan 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 insurance company 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.

With regard to 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.

With regard to 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.

See the ***Claims and Appeals Procedures*** section for additional information on filing claims, and procedures to appeal a claim that is wholly or partially denied.

SHORT-TERM DISABILITY

HOW THE SHORT-TERM DISABILITY PLAN WORKS

The Short-Term Disability Plan 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.

LIMITATIONS ON BENEFITS

The following sections describe the Short-Term Disability Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

WHEN COVERAGE BEGINS

You are covered for short-term disability benefits whenever you are working in Covered Employment. You do not need to work a specified number of hours to qualify for short-term disability benefits. Therefore, you may be eligible for disability benefits even when you do not qualify for Hospital and Medical benefits.

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 will fall under New York or New Jersey law depending on the state that 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. Please note that 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 is 66 2/3 % of your average weekly earnings at the time you became disabled up to a maximum benefit set by the State of New Jersey. The maximum changes 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 plan 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. Be sure to 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.

See the ***Claims and Appeals Procedures*** section for 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 ARE DISABLED FOR MORE THAN 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 Continuation of ***Coverage During Total Disability*** provision described in the section on eligibility and participation on page 8. 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. Remember, short-term disability benefits from the Fund will end after six months.

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

LIMITATIONS ON BENEFITS

The following sections describe the Scholarship and Recognition Program Benefits available under the Fund. Starting on page 114, the ***Claims, Claims Review and Appeals Procedures; Complaints, Appeals and Grievances for Claims Administered by Empire BlueCross BlueShield; Claims and Appeals for Prescription Benefits Administered by Express Scripts; Aetna Dental Claim Determinations, 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. Please note that if you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

ELIGIBILITY

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

- You are working for or have worked for an employer who is obligated to make contributions to the Welfare Fund on your behalf, which is referred to as "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 must be submitted.)

HOW THE SCHOLARSHIP PLAN 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 for this program 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 for this program 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 total and permanent disability, as defined by the Pension Fund, existed.

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 Scholarship and Recognition Program is not available for post-graduate work.

THE BENEFIT

The Scholarship and Recognition Program provided, Charles Johnson Jr. Memorial Scholarships, pays up to $3,500 for each year of a 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.

It is generally required that the $3,500 per year be used within four years from the initial award of the scholarship. However, in the event that a recipient takes a leave of absence from his/her 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 his/her academic program following the leave of absence. Please see page 119 for information concerning appeals to the Board of Trustees.

Any other financial assistance (e.g., awards from other sources including Local Unions, aid, loans) received by your Child must be reported to the Scholarship and Recognition Program. The Scholarship and Recognition Program adjusts the scholarship so that the combination of financial assistance and the award do not exceed total tuition, room and board expenses and usual fees. New York State Regents awards, however, are not taken into consideration. Please note that the Scholarship and Recognition Program benefit is paid directly to the educational institution, and not to the participant or Qualifying Child.

In the event your Child wins a scholarship award 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. Participants must review the special Scholarship and Recognition Program eligibility rules at the beginning of this section and their work history in Covered Employment. Any issue concerning participant eligibility must be resolved before your Child submits an application.

Participant eligibility will be reviewed after all applications have been submitted and evaluated. Children of participants who do not meet the special Scholarship and Recognition Program eligibility requirements will be eliminated from the competition. You may not request an eligibility review after your Child's application is submitted.

All 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 needs to take the College Board SAT Reasoning Test by December. Your Child must 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 and extracurricular activities, as well as writing samples from the applicant and letters of recommendation. Each candidate must be willing to accept the ISTS decision as final. The number of scholarships awarded is in the Trustees' sole discretion.

CONFIDENTIALITY

PERMITTED USES AND DISCLOSURES OF PHI BY THE FUND AND THE BOARD OF TRUSTEES

The Welfare Fund operates in accordance with the regulations under HIPAA with respect to Protected Health Information. A complete description of your rights under HIPAA is available in the Fund's Notice of Privacy Practices. The following statement is merely a summary of the key provisions of the Fund's Notice of Privacy Practices.

The term "Protected Health Information" ("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 (except for any information that is received in connection with the Life Insurance, Accidental Death and Dismemberment benefits or Disability benefits).

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 Benefit 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 Summary Plan Description, 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, or with respect to any other benefit or other employee benefit plan sponsored by the Board of Trustees without your specific written permission;
- 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 Board of Trustees will allow you, through the Fund, to inspect and photocopy your PHI to the extent, and in the manner, required by HIPAA;

- The Board of Trustees will make available to the Fund your PHI for amendment and incorporation of any such amendments to the extent and in the manner required by HIPAA;
- The Board of Trustees 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 Board of Trustees 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 Board of Trustees 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 Benefit 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 Fund Manager 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 Benefit Plan administration functions;
- If the Board of Trustees becomes aware of any noncompliance with the provisions outlined above by any of the individuals listed above, the Board of Trustees will promptly report the violation to the Fund's Privacy Officer and will cooperate with the Fund 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.

CLAIMS, CLAIMS REVIEW AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the Fund. It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. The claims procedures will vary depending on the type of your claim. The Welfare Fund has contracted with a number of health organizations ("Health Organization") to administer the different benefits components. 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 for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits;
- An inquiry about Fund eligibility that does not request benefits is not a claim for benefits;
- A request for verification of whether a particular service is covered under the Fund is not a claim for benefits;
- The presentation of a prescription to a pharmacy to be filled under the terms of the Fund is not a claim for benefits; or
- A request made by someone other than the claimant or his/her authorized representative is not a claim for benefits.

HOW TO FILE A CLAIM

A claim form may be obtained from the Fund Office by calling 800-529-3863 or from the specific Health Organization listed on page 115. The claim form should be completed in its entirety and submitted to the appropriate Health Organization or, for hearing, life insurance, AD&D, and disability benefits, to the Fund Office. 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 appropriate Health Organization. The applicable timeframe for processing the claim will begin to run from the date the claim is received at the appropriate Health Organization (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 yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The 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. Please note that 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 (1 year) after the date the charges were incurred. Life insurance claims must be filed in writing no later than 730 days (2 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 appropriate Health Organization that is responsible for making the initial determination of the claim. Urgent Care claims (explained below), however, may not be submitted in writing, but must be submitted by telephone to the appropriate Health Organization.

Where to Submit Your Initial Claim

When you receive Hospital, medical, behavioral health, prescription drug, dental, and vision services from an In-Network or Participating Provider, the Provider will submit a claim on your behalf. When you incur expenses for these services from an Out-of-Network or Non-Participating Provider, you are responsible for submitting a claim to the appropriate Healthcare Organization;

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:

Medco Health Solutions of Netpark, LLC
P.O. Box 30493
Tampa, FL 33630-3493

Dental claims must be submitted to:

Aetna
P.O. Box 14094
Lexington, KY 40512

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:

Guardian Life Insurance Company
Group Life Claims
P.O. Box 14334
Lexington, KY 40512

TIMEFRAMES 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 requests for approval that the Fund requires you to obtain before you receive medical care or obtain a prescription drug, such as pre-certification of an inpatient non-emergency Hospital stay or pre-authorization 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 BlueCross BlueShield 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. A request to reimburse you for a doctor visit or a request to reimburse you 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 are requests for benefits where the Fund must make a determination of total disability to decide the claim. The Fund reserves the right to have a Physician examine you (at the Fund's expense) as often as reasonable while a claim for disability is being decided. Disability claims must be decided no later than 45 days after the Fund receives the claim. The Fund can extend the timeframe 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 make a decision on 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 so long as 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 Fund 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.

REVIEW PROCESS

If your claim is denied in whole or in part, or if you disagree with the initial decision made on a claim, you may ask for a review by filing an appeal. Requests for review must be submitted to the appropriate Health Organization responsible for your claim.

Hospital and medical claims:

Empire
Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
800-553-9603

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:

Guardian Life Insurance Company
Group Life Claims
P.O. Box 14334
Lexington, KY 40512
800-525-4542

Dental claims:

Aetna
P.O. Box 14597
Lexington, KY 40512
Attn: Appeals Coordinator

New York Short-term disability:

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

New Jersey Short-term disability:

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
Claim Appeals
395 Hudson Street
New York, NY 10014

Separate sections in this SPD describe the review and appeal procedures used by Empire BlueCross BlueShield (page 121), Express Scripts (page 128) and Aetna Dental (page 132) in detail. Detailed information concerning claims review and appeals for dental claims can be found in the separate booklet issued by Aetna for these benefits that is available at **www.aetna.com**.

HOW TO FILE AN APPEAL

Your appeal must be made in writing within 180 days after you receive notice of denial. If the appeal is not submitted within this timeframe, 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 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 BOARD OF 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 request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached. The decision by the Board of Trustees or the Committee 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

Guardian 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 Fund 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 the Employee Retirement Income Security Act of 1974 ("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; and
- 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.

LIMITATIONS ON WHEN AND WHERE A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until you have requested a review and a final decision has been reached on review, or until the appropriate timeframe 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. However, a lawsuit may be started prior to you requesting or submitting a benefit dispute to any voluntary third level of 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 decides to take 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. 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, 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.

COMPLAINTS, APPEALS AND GRIEVANCES FOR CLAIMS ADMINISTERED BY EMPIRE BLUECROSS BLUESHIELD

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 will have to be redirected to Empire. The applicable timeframe for making the decision, as set forth below, will begin to run from the date the complaint, appeal, or grievance is received by Empire.

COMPLAINTS

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

Empire
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Member Services
800-553-9603

If your complaint concerns behavioral healthcare, call 800-342-9816 or write to:

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

Empire will resolve complaints within the following timeframes:

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

If you are not satisfied with Empire's decision on your complaint, you may file a grievance under the procedures described in the pages that follow.

PROVIDER QUALITY ASSURANCE

Empire has a Quality Assurance Program designed to ensure that its Network Providers meet Empire's high standards for care. Through this program, Empire continually evaluates its Network Providers.

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

YOUR RIGHT TO APPOINT A REPRESENTATIVE

You may appoint a representative to act on your behalf if you are not able to submit a complaint, grievance or appeal on your own. Call Empire's Member Services for a form. When completed forms are returned, Empire will note the name of your representative's name on its files.

STANDARD INTERNAL APPEALS

An appeal is a request to review and change an **Adverse Determination** (i.e., denied authorization of a service) made by Empire's Medical Management Program or Behavioral Health Management Program that a service is not Medically Necessary or is excluded from coverage because it is considered experimental or investigational. Appeals may be filed by telephone or in writing.

LEVEL 1 APPEALS

A Level 1 Appeal is your first appeal of the initial reduction or denial of services. You have 180 calendar days from the date of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

Empire will make a decision within the following timeframes for 1st Level Appeals.

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

Empire will provide a written notice of its determination to you or your representative, and your Provider, within two business days of reaching a decision.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal.

REMEMBER:

- A Level 1 Appeal submitted beyond the 180-calendar-day limit will not be accepted for review.
- A Level 2 Appeal submitted beyond the 60-business-day limit will not be accepted for review.

EXPEDITED LEVEL 1 APPEALS

You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue healthcare services, procedures or treatments that have already started.
- You need additional care during an ongoing course of treatment.
- Your Provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Appeals may be filed by telephone and in writing.

Please note that appeals of claims decisions made after the service has been provided cannot be expedited. When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum timeframes:

- You or your Provider will have reasonable access to Empire's clinical reviewer within one business day of Empire's receipt of the request.
- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal.
- Empire will notify you immediately of the decision by telephone, and within 48 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal appeal options.

LEVEL 2 APPEALS AND TIMEFRAMES

If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the date of the notice of the letter denying your Level 1 Appeal. If the Level 2 appeal is not submitted within that timeframe, Empire will not review it and its decision on the Level 1 appeal will stand. Appeals may be filed by telephone and in writing.

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

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

LEVEL 1 GRIEVANCES

A grievance is a verbal or written appeal of an Adverse Determination concerning an administrative decision not related to medical necessity. The types of decisions that may be reviewed through the grievance process include denials of a request for a referral to an Out-of-Network Provider, benefit denials based on a specific limitation in the SPD (e.g., no precertification was obtained), and complaint decisions where the individual disagrees with Empire's findings.

A Level 1 Grievance is your first appeal of Empire's administrative decision. You have 180 calendar days from the date of the notification letter to file a grievance. A grievance submitted beyond the 180-calendar-day limit will not be accepted for review.

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

A qualified representative (including clinical personnel, where appropriate) who did not participate in the original decision will review your grievance.

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

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

LEVEL 2 GRIEVANCES

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

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

- *Pre-service*: Empire will complete its review of a pre-service grievance within 15 calendar days of receipt of the grievance.
- *Post-service*: Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

EXPEDITED GRIEVANCES

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

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

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

DECISION ON GRIEVANCES

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

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

HOW TO FILE AN APPEAL OR GRIEVANCE

To submit an appeal or grievance, call Empire's Member Services at 800-342-9816, or write to the following address with the reason why you believe Empire's decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

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

If your grievance or appeal concerns behavioral healthcare, call 800-342-9816 or write to:

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

EXTERNAL REVIEW OF CERTAIN TYPES OF CLAIMS

If your appeal is denied, you may be eligible for an independent External Review pursuant to federal law. Claims that involve (1) medical judgment or (2) a rescission of coverage are eligible for External Review. Some examples of situations in which a claim is considered to involve medical judgment include adverse benefit determinations (full or partial claim denials) based on Empire's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or based on Empire's determination that a treatment is experimental or investigational.

As part of the External Review process, Empire has contracted with at least three Independent Review Organizations ("IROs") and has taken other steps to ensure that the External Review Process is independent and without bias.

If the outcome of your appeal to Empire is adverse to you, you may be eligible for an independent External Review. You must submit your request for External Review to Empire within four months of Empire's notice of decision on your first level appeal. You may choose to file a second level appeal to Empire before filing for External Review. However, please keep in mind that the filing of a second level appeal with Empire will not extend the four-month period from the date of the decision on Empire's first level appeal. Thus, if you intend to seek an External Review, you must do so within four months of Empire's notice of decision on your first level appeal even if your second level appeal is still pending.

A request for an External Review must be in writing unless Empire determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for the internal appeal. However, you are encouraged to submit any additional information that you think is important for review. Such requests should be submitted by you or your authorized representative to:

Anthem National Accounts
ATTN: Appeals, P.O. Box 5073
Middletown, NY 10940 – 9073

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 Empire's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Empire's decision, can be sent between Empire and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Empire at the number shown on your identification card and provide at least the following information:

- Identity of the claimant;
- Date(s) of the medical service;
- Specific medical condition or symptom;
- Provider's name;
- Service or supply for which approval of benefits was sought; and
- Reasons why the appeal should be processed on a more expedited basis.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations. 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 ERISA.

VOLUNTARY APPEAL TO THE BOARD OF TRUSTEES

If the two levels of appeal with Empire are denied, you then have the option to appeal to the Board of Trustee or duly designated Committee of Trustees. Your optional appeal must be filed within 60 days of the date of the decision of Empire's Level 2 appeal.

As with an External Review, you are not required to file a voluntary appeal to the Board of 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 Welfare Fund. The Board of Trustees' or Committee's decision is final and binding on all parties except for any relief available through ERISA.

Your appeal to the Board of Trustees must be made in writing. No verbal appeals will be accepted. Once the appeal is received, the Board of Trustees will verify if Empire has previously issued a denial. If you have not filed first and second level appeals to Empire, you will have forfeited your right to an optional appeal to the Board of Trustees.

If you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

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 will have to be redirected to Express Scripts. The applicable timeframe for making the decision, as set forth below, will begin to run from the date the claim is received at Express Scripts (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, a claim form may be obtained from the Fund Office by calling 800-529-3863 or from Express Scripts. 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. 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 the prescription has 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.

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, in all circumstances, claims should be filed 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, however, may not be submitted in writing, but must be submitted by telephone to Express Scripts.

WHERE TO SUBMIT YOUR PRESCRIPTION DRUG CLAIMS

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

CLAIMS REVIEW PROCESS

After you submit a properly completed claim form, Express Scripts will review the claim and make a decision within the applicable timeframes 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 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 Fund 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 your claim is denied in whole or in part, or if you disagree with the initial decision made on a claim, you may ask for a review by filing an appeal 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 Fund.

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 timeframe, Express Scripts will not review it and its initial decision will stand.

The contact information for Express Scripts is provided below:

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

TIMEFRAMES 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), Express Scripts will complete its review of your written 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 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), Express Scripts will complete its review of your written appeal within 30 days of receipt of the appeal or grievance.

Third Level. The third level of appeal is a voluntary procedure. Should an Adverse Determination be made upon review of your claim by Express Scripts, you will have an opportunity to choose a voluntary third level of appeal before the Board of Trustees. To request this third level voluntary appeal, or if you have any questions, please call the Fund Office. This third level of appeal is not required by the Fund and is only available if you or your authorized representative request it. This third level of appeal must be filed within 60 days of the date of the denial of the second level appeal or grievance.

The voluntary level of appeal is available only after you have pursued the appropriate mandatory appeals process required by the Fund, as indicated previously in this section. 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 level of appeal. Where you choose to pursue a claim in court after completing the voluntary appeal, the Fund agrees that 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 with medical experts that 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. (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day.)

To submit an external review, the request must be mailed or faxed to:

Express Scripts
Attn: External Review Requests
P.O. Box 66587
St. Louis, MO 63166-6587
800- 946- 3979 (phone)
877- 328- 9660 (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 the claimant 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 the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to Express Scripts for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, 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 the claimant in writing that the claim is ineligible for a full 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 i n 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 the claimant 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 the claimant written notice of its decision.

APPEALS HEARD BY THE BOARD OF TRUSTEES

Your appeal to the Board of Trustees or a Committee of Trustees must be made in writing. No verbal appeals will be accepted. Once the appeal is received, the Trustees will verify if Express Scripts has previously issued a denial. If you have not filed first and second level appeals to Express Scripts, you will have forfeited your right to an optional appeal to the Board of Trustees or Committee.

Decisions on appeals involving prescription benefits will be made by the Board of Trustees, or a Committee of 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, but no later than five days after the decision has been reached. The decision by the Board of Trustees or Committee shall be final and binding on all parties.

AETNA DENTAL CLAIM DETERMINATIONS, COMPLAINTS & APPEALS

CLAIM DETERMINATIONS

Aetna will provide notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the claim. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days.

If your claim is denied, Aetna's notice will provide:

- The reasons for the denial (referred to here as an adverse benefit determination), including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the Fund's review procedures, including a statement of your rights to bring a civil action;
- Instructions on how to start the appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the adverse benefit determination. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on appeal; and
- The notice will be sent to you, your designee and your dentist.

In the event that Aetna renders an adverse benefit determination without first attempting to discuss the matter with your dentist who specifically recommended the service, procedure or treatment, the dentist will have the opportunity to request a reconsideration of the adverse benefit determination. If the adverse benefit determination is upheld, Aetna will provide notice, as described above.

If Aetna does not render a decision within the period set forth above, you may consider this to be an adverse benefit determination, subject to appeal.

COMPLAINTS

If you are dissatisfied with the service you receive from Aetna or want to complain about a dentist, you must call or write Aetna Customer Service. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 15 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

You can make a complaint by calling Aetna Member Services at 855-201-8436. If you leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

For written complaints, an acknowledgement letter will be sent to you within 15 days of Aetna's receipt of the complaint. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter. Written complaints should be mailed to:

Aetna
P.O. Box 14463
Lexington, KY 40512

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

You may submit an appeal if Aetna gives notice of an adverse benefit determination. The Fund provides for two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your Level One appeal. Your appeal may be submitted orally or in writing. The request should include:

- Your name;
- The Policyholder's name;
- A statement from your dentist;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send your appeal to:

Aetna
PO Box 14597
Lexington, KY 40512

You may also appeal by calling Aetna Customer Service at 855-201-8436.

You may also choose to have an authorized designee make the appeal on your behalf by providing written consent to Aetna. Your health care Provider may also make the appeal.

LEVEL ONE APPEAL

A Level One appeal of an adverse benefit determination will be decided by Aetna personnel not involved in making the original adverse benefit determination.

Aetna shall issue a decision within the earlier of 15 days of receipt of the necessary information to conduct the appeal or 30 days of receipt of the request for an appeal.

The notice of the appeal determination will include:

- If the adverse benefit determination is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of your right to an external appeal, together with information and a description of the external appeals process. You also have the option to request a Level Two appeal from Aetna.

If Aetna does not render an appeals determination for an appeal within the timeframes set forth above, the adverse benefit determination will be reversed.

LEVEL TWO APPEAL

If Aetna upholds an adverse benefit determination at the Level One appeal, you or your authorized representative have the option to file a Level Two appeal or to request an External Appeal. The Level Two appeal, if requested, must be submitted within 60 calendar days following the receipt of notice of a Level One appeal determination. Please note that if you decide to pursue a Level Two appeal and wait for a decision from Aetna, you may miss the deadline to request an External Appeal from your state insurance department or other regulatory agency. Also, you may wish to end your Level Two appeal once you receive notice from the state insurance department, or other similar entity, that your request for an External Appeal has been received and is being sent out for review.

A Level Two appeal of an adverse benefit determination will be reviewed by the Aetna Appeals Committee.

Aetna will issue a decision within 30 calendar days of receipt of the request for a Level Two appeal.

EXTERNAL REVIEW

Your Right to an External Appeal. Under certain circumstances, you may have a right to an external appeal of a denial of coverage. The external review process varies from state to state. If you are considering an external appeal, please review your specific Dental Plan documents for external appeal instructions by visiting **www.aetna.com**.

If you are eligible for an external appeal and you choose to exercise this option, your appeal will be considered by an independent agent not affiliated with Aetna or the Fund.

To request an external review, any of the following requirements must be met:

- You have received a claim denial notice from Aetna, and Aetna did not adhere to all claim determination and appeal requirements;
- You have received a final internal adverse benefit determination from Aetna;
- Your claim was denied because Aetna determined that the care was not Medically Necessary or was experimental or investigational; or
- You have exhausted the applicable Aetna internal appeal process.

OTHER INFORMATION YOU SHOULD KNOW

BENEFIT 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 Benefit Plan at any time. Upon termination of the Benefit Plan, the Trustees shall apply the monies of the Fund to provide benefits or to otherwise carry out the purposes of the Benefit 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.

BENEFIT PLAN INTERPRETATION

In carrying out their respective responsibilities under the Benefit Plan, the Board of Trustees and other Benefit Plan fiduciaries and individuals to whom responsibility for the administration of the Benefit Plan has been delegated have discretionary authority to interpret the terms of the Benefit Plan and to determine eligibility and entitlement to Benefit Plan benefits in accordance with the terms of the Benefit Plan, and to decide any fact related to eligibility for and entitlement to Benefit 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, because of failure to provide care or treatment, or otherwise.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Benefit 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 Benefit 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 Benefit 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 Benefit Plan to exercise the Benefit Plan's rights and do nothing to prejudice those rights;
- In the event that you or your legal representative fail to do whatever is necessary to enable the Benefit Plan to exercise its subrogation rights, the Benefit Plan shall be entitled to deduct the amount the Benefit Plan paid from any future benefits under the Benefit Plan;
- The Benefit 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 Benefit Plan;
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Benefit Plan's subrogation claim and any claim held by you, the Benefit 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 Benefit Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Benefit Plan's prior written consent. The ''common fund'' doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Benefit Plan.

REIMBURSEMENT

If you obtain a Recovery and the Benefit Plan has not been repaid for the benefits the Benefit Plan paid on your behalf, the Benefit 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 Benefit Plan from any Recovery to the extent of benefits the Benefit 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 Benefit Plan shall have a right of full recovery, as permitted by applicable law, in first priority, against any Recovery. Further, the Benefit Plan's rights will not be reduced due to your negligence;

- You and your legal representative must hold in trust for the Benefit 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 Benefit Plan immediately upon your receipt of the Recovery, as permitted by applicable law. You must reimburse the Benefit 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 any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Benefit Plan;
- If you fail to repay the Benefit Plan, the Benefit Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Benefit Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Benefit Plan if:
  - The amount the Benefit Plan paid on your behalf is not repaid or otherwise recovered by the Benefit Plan, or
  - You fail to cooperate;
- In the event that you fail to disclose the amount of your settlement to the Benefit Plan, the Benefit Plan shall be entitled to deduct the amount of the Benefit Plan's lien from any future benefit under the Benefit Plan;
- The Benefit Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Benefit 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 Benefit 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 Benefit Plan will not have any obligation to pay the Provider or reimburse you; and
- The Benefit 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 Benefit 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 Benefit Plan in the investigation, settlement and protection of the Benefit Plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Benefit Plan to exercise its subrogation or reimbursement rights, the Benefit Plan shall be entitled to deduct the amount the Benefit Plan paid from any future benefits under the Benefit Plan;
- You must not do anything to prejudice the Benefit Plan's rights;
- You must send the Benefit 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 Benefit 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 this Benefit 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 Benefit 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 Benefit Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies; and
- The Benefit Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

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 Board of 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.

HEALTHCARE FRAUD

Illegal activity adds to everyone's cost for healthcare. That's why we welcome your help in fighting fraud. If you know of any person receiving Empire benefits who is not entitled, call Empire. Empire will keep your identity confidential. If you want to see some recent examples of Empire's fraud prevention efforts, you can visit **www.empireblue.com**. If you know of any other fraud being committed with respect to the Fund, call the Fund's Chief Compliance Officer at 646-484-1665.

Remember: You can call Empire's Fraud Hotline at 800-I-C-FRAUD (423-7283) during normal business hours.

STOP PAYMENTS ON CHECKS

In the event that the Fund has issued you a payment, for example, for short-term disability or reimbursement on a health claim, and you need to request that the Fund "stop payment" on such check and issue a new check, your request for a "stop payment" must be made within six (6) months of the date of issuance of the initial payment. If the request is not made within six (6) months, no re-payment will be issued.

OTHER ADMINISTRATIVE AND FUNDING INFORMATION

This section provides important information about third parties involved in providing and administering benefits.

Medical and behavioral health benefits. Benefits for Active Employees are self-funded; that is, they are paid out of Fund assets. The Fund has contracted with Empire BlueCross BlueShield (Empire) to administer the In-Network and Out-of-Network programs on its behalf.

In addition to forwarding to Empire amounts required to pay Medical Plan benefits, the Fund also pays Empire an administrative fee. Empire then 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
800-553-9603
www.empireblue.com

Prescription drug benefits. Benefits under this program 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 Prescription Drug Plan benefits, the Fund also pays Express Scripts an administrative fee. Express Scripts can be reached at:

Express Scripts
www.express-scripts.com

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)

For Medicare-Eligible Participants:
Express Scripts
P.O. Box 630406
Irving, TX 75063
Attn: Medicare Admin Appl
800-311-2757 (phone)
888-235-8551 (fax)

Dental benefits. Benefits under this program are insured by Aetna Life Insurance Company. The Fund pays premiums to Aetna for the coverage and Aetna assumes responsibility for the payment of benefits. Aetna can be reached at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
855-201-8436
www.aetna.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 under these plans are insured by Guardian Life Insurance Company (Guardian). The Fund pays premiums to Guardian for the coverage and Guardian assumes responsibility for the payment of benefits. Guardian can be contacted at:

Guardian Life Insurance Company
Group Life Claims
P.O. Box 14334
Lexington, KY 40512
800-525-4542 (Hours 8:00 am to 4:30 pm EST Monday through Friday)

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).

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 Benefit Plan participants are entitled to certain rights, as outlined in the following information.

RECEIVE INFORMATION ABOUT YOUR BENEFIT 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 Benefit Plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Benefit 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 Benefit Plan Administrator, copies of documents governing the operation of the Benefit Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD (the Benefit 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 Benefit Plan as a result of a qualifying event. You or your dependent(s) may have to pay for such coverage.

PRUDENT ACTIONS BY BENEFIT PLAN FIDUCIARIES

In addition to creating rights for Benefit Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate your Benefit Plan, called fiduciaries of the Benefit Plan, have a duty to do so prudently and in the interest of you and other Benefit 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 Benefit Plan's claims and appeals procedures. If you or your Beneficiary decides to take 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. The lawsuit must be filed in the United States District Court for the Southern District of New York in New York County, New York.

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 Benefit 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 Benefit 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 Benefit Plan Administrator. See the section on ***Limitations on When and Where a Lawsuit May Be Started*** for additional information regarding such suits.

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 Benefit Plan fiduciaries misuse the Benefit 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 Benefit Plan, you should contact the Benefit 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 Benefit Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (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, prescription drug, dental, life insurance and vacation benefits.
Funding of Benefits	All 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 Welfare Fund at fixed rates. A copy of any such agreement may be requested or examined at the Fund Office. In addition, Retirees and surviving spouses pay a premium for their coverage.
Trust	Contributions to the Welfare 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.
Benefit Plan Administrator	The New York City District Council of Carpenters Welfare Fund is administered by a Board of Trustees composed of twelve trustees: six designated by employer associations and six 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
Benefit Plan Sponsor	The New York City District Council of Carpenters 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 Welfare Fund on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and Unions participating in the Welfare 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 Benefit Plan Administrator, the individual Trustees, any insurer of benefits, or, with regard to any such insurer, the supervisory official of the local state insurance department.

MEMBERS OF THE BOARD OF TRUSTEES

TRUSTEES DESIGNATED BY THE DISTRICT COUNCIL

	Title	Address
Joseph Geiger	Co-Chairman New York City District Council of Carpenters	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Paul Capurso	Trustee New York City District Council of Carpenters	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Michael Cavanaugh	Trustee New York City District Council of Carpenters	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Stephen McInnis	Trustee New York City District Council of Carpenters	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
John Sheehy	Trustee New York City District Council of Carpenters	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Paul Tyznar	Trustee New York City District Council of Carpenters	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014

TRUSTEES DESIGNATED BY EMPLOYER ASSOCIATIONS

	Title/Employer Association	Address
David T. 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
Catherine Condon	Trustee Manufacturing Woodworkers Association of Greater New York, Inc.	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
Paul J. O'Brien	Trustee Building Contractors Association	New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014
Kevin M. O'Callaghan	Trustee The Hoist Trade 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 Union 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	The Allowed Amount is the maximum charge the plan recognizes for any service and on which plan payments are based.
Beneficiary	The individual(s) or entity that you name to receive benefits under the Life Insurance and Accidental Death and Dismemberment insurance coverage, upon your death.
Ambulatory Surgery	See "Same-Day Surgery."
Annual Out-of-Pocket Coinsurance Maximum	The most you will have to pay in out-of-pocket costs for Coinsurance on Covered Services received during a calendar year. When you meet the out-of-pocket Coinsurance maximum, the plan pays 100% of the Maximum Allowed Amount for covered expenses for the remainder of that calendar year. Your Copayments, Deductible and any amount you pay above the Out-of-Network Maximum Allowed Amount do not count toward your Annual Out-of-Pocket Coinsurance 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	When you are working for an employer that is required by a collective bargaining agreement to contribute to the Fund on your behalf, you are in Covered Employment.
Covered Services	The services for which Empire provides benefits under the terms of your contract. For example, Empire covers one In-Network annual physical exam.
Deductible	The dollar amount you must pay each calendar year before your 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, your POS plan will pay benefits for covered In-Network or Out-of-Network services for the remainder of the year for all eligible family members. Please note that there are separate In-Network and Out-of-Network deductibles under the plan.

Disabled Child or Children	A Disabled Child is an 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.
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 BlueCross and/or BlueShield 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 BlueCross and/or BlueShield 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 BlueCross and/or BlueShield plan. In other states, the Facility must participate with another BlueCross and/or BlueShield 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 Coinsurance maximum, the plan will pay 100% of Empire's Maximum Allowed Amount. Please note that In-Network Coinsurance cannot be applied towards meeting your annual Out-of-Network Coinsurance. 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 BlueCross and/or BlueShield plan • Has a negotiated rate arrangement with another BlueCross and/or BlueShield 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.
Maximum Allowed Amount (MAA)	The maximum dollar amount of reimbursement for Covered Services. Please see the Maximum Allowed Amount Reimbursement for Covered Services section for additional information.
Medically Necessary	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 does not have a participation agreement with Empire or another BlueCross and/or BlueShield plan to provide services to persons covered under Empire's POS or PPO contract. Or a Hospital or Facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.
Operating Area	Empire 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 Coinsurance maximum, you will not be required to pay Coinsurance, but you will be responsible to pay the difference between the Provider's actual charge and Empire's Maximum Allowed Amount. This is not applied to the Deductible and Coinsurance amounts. 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 BlueCross and/or BlueShield plan • Does not have a negotiated rate with another BlueCross and/or BlueShield 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 BlueCross and/or BlueShield plan • Has a negotiated rate arrangement with another BlueCross and/or BlueShield plan that does not have a PPO network
Benefit Plan Administrator	The Board of Trustees
Precertified Services	Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs before you receive them to be fully covered by your plan.
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 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. 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	Retiree includes: 1. Individuals receiving retirement benefits from the Pension Fund 2. Individuals who are Totally and Permanently Disabled 3. Surviving dependents *Each of the above satisfy the Retiree eligibility requirements for the Welfare Fund and are paying the applicable premiums.
Same-Day Surgery	Same-day, ambulatory or Outpatient Surgery is surgery that does not require an overnight stay in a Hospital.

Totally and Permanently Disabled	During the first 24 months after you stop working due to a disability, you will be considered Totally and Permanently Disabled if you are unable to perform work in Covered Employment. After 24 months, you will be Totally and Permanently Disabled if you are in receipt of Social Security disability benefits.
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.