

**Health and Benefit Trust Fund of the
International Union of Operating Engineers
Local 94-94A-94B, AFL-CIO**

**ACTIVE AND RETIREE MEMBERS
SCHOOL DIVISION**



SUMMARY PLAN DESCRIPTION

JANUARY 1, 2018

**337 WEST 44TH STREET
NEW YORK, NY 10036
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Summary Plan Description
for the
Health and Benefit Trust Fund
of the
International Union of Operating Engineers
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SCHOOL DIVISION

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January 1, 2018

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Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO

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To: All School Division Members and Beneficiaries

**From: Trustees of the Health and Benefit Trust Fund
of the I.U.O.E. Local 94-94A-94B, AFL-CIO**

We are pleased to present you with this Summary Plan Description (“SPD”), which describes the benefits offered under the plan of benefits (the “Plan”) of the Health and Benefit Trust Fund of the International Union of Operating Engineers, Local 94-94A-94B, AFL-CIO (the “Fund”), that were in effect as of January 1, 2018 (unless specified otherwise herein).

The Fund covers eligible employees of the International Union of Operating Engineers of the Local Union 94- 94A- 94B, AFL-CIO (“Union” or “Local 94”); the Fund; the Training Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO; the Annuity Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO; and of the various employers who are required to contribute to the Fund pursuant to the terms of a collective bargaining or other written agreement with the Union.

As described more fully in this SPD, the Plan provides health benefits to eligible Members through agreements with Empire Blue Cross Blue Shield (“Blue Cross”), CVS/Caremark and Sele-Dent Inc. (“Sele-Dent”), the Fund’s other various vendors as well as from the general assets of the Fund.

The primary purpose of this description is to provide you with a non-technical explanation of the most important features of the health benefits available to you. To this end, this booklet contains a summary in English of legal facts and your rights and responsibilities under the Plan. We urge you and your family to read this SPD carefully, so that you will understand the Plan as it applies to you. Failure to understand your obligations and rights under the Plan may lead to the denial of benefit claims.

This SPD constitutes the Plan’s written plan document and SPD in accordance with ERISA. This SPD supersedes all prior SPDs, plan rules and other notices issued prior to the effective date of this SPD. This SPD applies to services rendered on or after the effective date of its issuance, January 1, 2018. For services rendered prior to that date, please refer to the Fund’s prior Summary Plan Description, notices and documents for the applicable period.

Additional information about the Plan is available in the other official Plan documents, including the Trust Agreement or the Plan’s respective contracts and certificate of insurance booklets with its insurers, preferred provider organizations and pharmacy benefit managers (currently Empire Blue Cross Blue Shield, CVS/Caremark or Sele-Dent), or applicable collective bargaining or other written agreements between your Contributing Employer and the Union. All statements made in this SPD booklet are subject to the provision and terms of those other official plan documents. If there is any conflict between these documents and the SPD, these official plan documents will control instead of the SPD.

Your rights to benefits can only be determined by the Plan, as interpreted by official action of the Fund’s Board of Trustees (“Board” or “Trustees”). In addition, the Board reserves the right, in its sole discretion, to amend the Plan at any time.

If you have difficulty understanding any part of this SPD, contact the Fund Office in writing to the Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO, 337 West 44th Street, New York, NY 10036. For assistance, you may also call the Fund Office at (212) 541-9880 or visit the Fund’s website at: <http://www.local94.com>. The Fund Office’s hours of operation are from 8 a.m. to 4 p.m. Monday through Friday. All official plan documents are available for your inspection at the Fund Office during normal business hours.

With our very best wishes,

Board of Trustees of the Health & Benefit Trust Fund

Local 94-94A-94B

Important Information

IMPORTANT INFORMATION

You should refer to this SPD when you need information about your Plan benefits. To this end, this SPD provides an overview of the benefits available from the Plan. It also discusses when you (or your Eligible Dependents) are eligible to receive benefits and how they will be paid. Please remember to (or that):

Save this booklet – put it in a safe place. If you lose a copy, you can request that the Fund Office provide you with another copy.

If you change your name, address, marital status – notify the Fund Office immediately so your records are kept up-to-date.

Capitalized words herein are generally defined in the Glossary herein. Words and phrases not defined in this Article shall have the meaning set forth in the Fund’s respective agreements and/or certificate of insurance booklets with Empire Blue Cross Blue Shield, CVS/Caremark and Sele-Dent, and if not defined in these documents, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

Throughout this SPD, the words “you” and “your” refer to Members whose employment or retirement status makes them eligible for Plan benefits. The word “Eligible Dependent” refers to a family member of a Member who is eligible for Plan benefits. In the sections describing the benefits payable to Members and dependents, the words “you” and “your” may also be used to refer to the patient.

This SPD describes the provisions of the Plan in effect as of January 1, 2018, unless specified otherwise.

In the event that there is any conflict between the terms and conditions for Plan benefits as set forth in this SPD and any oral advice you receive from a Fund employee or union representative, the terms set forth in this SPD shall control.

This booklet is not a contract of employment – it neither guarantees employment or continued employment with any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any employee.

YOUR HEALTH BENEFITS COVERAGE AT-A-GLANCE

The goal of the Plan is to provide you and your family with comprehensive medical benefits. To meet this goal, there are four sources of medical benefits available to you as a Member:

PPO benefits and hospital benefits through Empire Blue Cross Blue Shield,

Prescription benefits through CVS/ Caremark,

Dental benefits through Local 94 and Sele-Dent, and/or

Certain non-PPO benefits, such as Eye Care, Annual Physicals, Hearing Aids, Loss of Time & Death Benefits, are self-administered directly by the Fund.

These four (4) sources combined will provide you, as a Member, and your Eligible Dependents with comprehensive coverage for health expenses you or they may incur.

Please note that the Plan offers certain eligible pensioners of the Central Pension Fund, who meet the stated criteria certain benefits as described in Section 4 herein.

We also note that the Fund issues an annual Summary of Benefits and Coverage (“SBC”) in accordance with the applicable disclosure requirements under the Health Care Reform law. Generally speaking, the SBC is designed to provide a high-level summary of the Fund’s benefits in a specific format so that you can conduct an “apples-to-apples” assessment of those benefits (and the cost for them) when comparing the Fund to different health plan coverage. Fortunately, the coverage under the Fund is based on a Collective Bargaining Agreement between your employer and the Union; and, as of the effective date of this SPD, has been determined to be affordable and satisfy the minimum value requirements under the Health Care Reform law.

GLOSSARY

Accidental Injury: An injury resulting from an accident such as an automobile accident, a fall, being hit by a falling object, an accident with a knife or other sharp object, etc.

Assignment of Plan Benefits: Written authorization from a Member to pay any benefits due directly to the service provider. (Important note: When the provider is not participating in one of the Plan's provider networks, ALL payments are made directly to the Member.)

Calendar Year: January 1 to December 31.

COBRA (also referred to as "COBRA Continuation Coverage"): COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder.

Co-insurance: For PPO benefits, co-insurance is the percentage of the negotiated rate for which you are responsible when services are provided by any provider.

Contributing Employer: A person, company or other employing entity, who is required to contribute to the Fund pursuant to a collective bargaining or other written agreement with the Union; an employer (including the Union; the Training Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO; and the Annuity Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO) acceptable to the Trustees, who is required to contribute to the Fund pursuant to a participation agreement; or the Fund.

Coordination of Benefits (also referred to as "COB"): The order and methods of payment used when another plan or carrier outside the Plan is involved.

Co-payment: Amount of PPO covered charges not paid by the Fund that you must pay out-of-pocket when services are provided by a participating provider.

Cosmetic Surgery: Surgery performed solely for the purpose of improving someone's physical appearance.

Covered Employment: Employment in a classification for which your Contributing Employer is required to make contributions to the Fund.

Covered Providers: Providers of medical, dental, prescription drug and/or vision services whose services (such as hospitals, doctors, labs, etc.) may be paid or for which you may be reimbursed under the Plan.

Deductible: The amount of covered charges incurred that must be paid by you before benefits under the Plan will be paid by the Plan or PPO, as the case may be.

Eligible Dependents: means those Members' spouse and family members who satisfy the eligibility requirements under Section 1 and enroll in the Plan.

Empire Blue Cross Blue Shield: The PPO network leased from Empire Blue Cross Blue Shield and Hospitalization.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Fund: The Health and Benefit Trust Fund of the International Union of Operating Engineers, Local 94-94A- 94B, AFL-CIO.

Fund Office Administered Benefits: Benefits for which the Fund provides any payment to which you may be entitled.

Glossary

HIPAA: The Health Insurance Portability and Accountability Act of 1996, which is a federal law that imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund.

Hospitalization: Benefits and services provided by a hospital.

In-Network: Benefits provided by Covered Providers who have contracted with the Fund, BlueCross, Sele-Dent or with any administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services provided must fall within the scope of their individual professional licenses.

Incurred Date: The date on which a medical, surgical, dental, or other service for which a charge was made, was performed.

I.U.O.E.: International Union of Operating Engineers.

Licensed Physician: A medical doctor, licensed by the appropriate board, acting within the scope of his or her medical license. Healthcare providers other than medical doctors may be permitted to provide certain covered services under the Plan, as determined by Empire Blue Cross Blue Shield and the Board of Trustees. However such providers must be licensed by the appropriate board and/or State and acting within the scope of their license.

Locals 94-94A- 94B: Local chapters of the Union.

Medically Necessary: Means medical services, supplies and/or equipment that are deemed to be required by accepted standards of medical practice, as determined by the Board, in its sole and absolute discretion, in consultation with Empire Blue Cross Blue Shield and/or the Fund's other various vendors; provided that such medical services, supplies and/or equipment satisfies all of the following criteria:

Are provided by a medical physician, hospital or other provider of health care services,

Are consistent with the symptoms or diagnosis and treatment of an illness or injury; or are preventive in nature, such as annual physical examinations, well-woman care, well-child care and immunizations, and are specified by the Plan as covered,

Are not experimental, except as specified otherwise in this SPD,

Meet the standards of good medical practice,

Meet the medical and surgical appropriateness requirements established under the Empire Blue Cross Blue Shield's medical policy guidelines,

Provide the most appropriate level and type of service that can be safely provided to the patient, and

Are not solely for the convenience of the patient, the family or the provider, and are not primarily custodial.

Member: means: (a) an individual in the Plan who is working for a Contributing Employer under the terms of a collective bargaining or other written agreement (such as a participation agreement) with the Union that requires such Contributing Employer to contribute to the Fund and who works the required number of hours per calendar period, as detailed in Section 1: Eligibility as set forth herein ("Active"); (b) a Retiree; and/or (c) any eligible individual who has elected COBRA Continuation Coverage.

Non-participating Provider Benefits (also referred to as "Out-of-Network Benefits"): Benefits and/or services which are rendered by a "Provider" that is not with one of the Plan's participating networks.

PEMG: Professional Evaluation Medical Group.

Plan: The Health and Benefit Trust Fund of the International Union of Operating Engineers, Local 94-94A- 94B, AFL-CIO as it applies to the School Division, Fund, Union and related fund employees.

PPACA: The Patient Protection and Affordable Care Act of 2010 (also commonly referred to as "Affordable Care Act" or "Health Care Reform").

Glossary

Preferred Provider Organization (referred herein as “PPO”): A network of physicians and other health care providers (e.g., Covered Providers) who agree to offer services and/or medical supplies according to an established fee schedule and/or pre-negotiated rate under the medical, dental, prescription drug and/or vision plans. Services must fall within the scope of the physicians’ or the health care providers’ respective individual professional licenses.

Retirees: Members who are receiving pension benefits under the Central Pension Plan and who satisfy the eligibility requirements under Section 1 of this SPD. Eligible Retirees are permitted to only receive the Death Benefit and the Medicare Premium Reimbursement benefits provided under this SPD. As such, other than the Death Benefit and the Medicare Premium Reimbursement benefits, no other benefits under this SPD are offered or made available to Retirees.

TRICARE (which was formerly known as CHAMPUS - the Civilian Health & Medical Program of the Uniformed Services): The health services and support program for U.S. Military Personnel on active duty, U.S. Military retirees, and their families.

Union: The International Union of Operating Engineers Local 94-94A-94B, AFL-CIO.

Workers’ Compensation: Payments made to individuals if they are injured in the course of or arising from their employment according to state law.

ELIGIBILITY

WHEN COVERAGE BEGINS

You will be eligible to participate in the Plan if:

You are an employee of a Contributing Employer under the terms and provisions of a collective bargaining or other written agreement with the Union that requires such Contributing Employer to make contributions to the Fund,

You are an employee of a Contributing Employer which is under the terms and provisions of a collective bargaining or other written agreement with the Union requiring such Contributing Employer to make contributions to the Fund,

You are an employee of the Fund, or

You are an employee of the Union, the Training Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO, or the Annuity Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO and such Contributing Employer is required to contribute to the Fund pursuant to a participation agreement with the Trust;

and provided that you meet certain other requirements as set forth below.

If you are eligible to participate in the Fund you must be a Member. You may not reject or waive coverage by the Fund for yourself or your Eligible Dependents. Accordingly, there is no “opt-out” provision that would otherwise allow employees and/or Members to reject coverage under the Fund. In this regard, if you are also covered under another group health plan (including your spouse’s group health plan), the Fund will consider such coverage under that plan as secondary coverage and the Fund’s coverage as your primary coverage.

Initial Eligibility for Members Who Are Active

Effective as of January 1, 2014, new members of the Union and new employees of Contributing Employers will have to accrue 400 paid hours in Covered Employment within a six (6) consecutive month measurement period commencing as of their start date of covered employment to become eligible for benefits under the Fund. For the purpose of the six month waiting period, if you begin employment before the 16th of any month you will be deemed to have commenced employment on the first of that month and if you began after the 15th you will be deemed to have started the first of the next month. You will become eligible for benefits under the Fund as of the first day of the second month following the date that you accrued the 400 paid hours in Covered Employment within the applicable six (6) month measurement period. If you don't meet the eligibility requirements in the initial six month measurement period, a subsequent six month consecutive period will begin as of the first date of any subsequent month following your start date. As such, subsequent measurement periods can overlap, in part, with prior measurement periods. This will enable you to apply the relevant covered hours that span over multiple measurement periods in order to meet the 400 paid hours requirement.

For example, if you begin Covered Employment on January 15, 2014 and accumulate at least 400 hours on February 28, 2014, you will be eligible to participate in the Plan on April 1, 2014. If, however, you begin Covered Employment on January 15, 2014 and do not accumulate at least 400 hours through June 15, 2014 (i.e., the last day of the initial measurement period), you will not be eligible for coverage under the Fund until you satisfy the hours requirement for a subsequent measurement period. As an example, this could be achieved by accumulating the necessary hours in a subsequent measurement period that for instance runs from March 1, 2014 through August 31, 2014. If, during this subsequent measurement period (i.e., March through August), you accrue the required 400 hours on August 17, 2014, you will be able to participate on October 1, 2014.

Exception: If you were affiliated with Local 94B and were transferred to Local 94 or 94A you will have a waiting period of one month before becoming eligible to first participate in the Plan. Additionally, if you were affiliated with an employer from the Commercial Division and transferred to an employer with the School Division you will have a waiting period of one month before becoming eligible to first participate in the Plan. For purposes of the one month waiting period, if you begin employment before the 16th of any month you will be deemed to have commenced employment on the first of that month and if you began after the 15th you will be deemed to have started the first of the next month.

Section 1: Eligibility

Continuing Eligibility for Members Who Are Active

A Member must accumulate at least 400 paid hours in Covered Employment in a calendar quarter to be eligible for the second calendar quarter following that calendar quarter. For example, if you have earned at least 400 paid hours in Covered Employment January, February, and March you will be covered for your benefits for July, August, September, provided you remain employed with your Contributing Employer during that period.

If a Member (who is continuously employed in Covered Employment) does not satisfy the continuing eligibility requirements in a calendar quarter (which would make him/her eligible for the second following quarter), but has accumulated more than 400 paid hours in Covered Employment in the immediately preceding calendar quarter, the excess hours (i.e., above 400 hours) paid in the immediately preceding quarter will be counted in determining the hours earned in that quarter. For example, if you are a Member and you were paid 450 hours in Covered Employment in January, February, and March and you were paid 350 hours in Covered Employment in April, May and June, you will be covered for benefits for July through December. This provision will not apply in the event that the Member's failure to satisfy the continuing eligibility requirements is a result of a personal non-FMLA leave of absence or termination of employment.

Note: Eligibility will cease on the last day of the month following the month in which you terminate employment or, if earlier, the last day of the month following the calendar quarter in which you fail to accumulate at least 400 paid hours.

Reinstatement

If you are a Member who loses coverage because you fail to meet the continuing eligibility requirements described above, you will again be covered for benefits one (1) month after continuous reemployment with the Contributing Employer (for which contributions are required to be made to the Fund), provided that

- (i) **You were employed at least one (1) full year with a Contributing Employer (for which contributions were required to be made to the Fund) immediately prior to the date of such termination of coverage**
and
- (ii) **The period during which you were not covered for benefits after failing to meet the continuing eligibility requirements is less than two (2) years.**

For the purposes of the one (1) month waiting period, if you begin employment before the 16th of any month you'll be deemed to have commenced work on the first of that month, and if you begin employment after the 15th you'll be deemed to have commenced employment on the first of the following month.

Eligible Dependents

When you are eligible for Plan benefits, the following members of your family are considered your Eligible Dependents: **Your lawful married spouse. In light of the United States Supreme Court's recent rulings on the federal Defense of Marriage Act, effective as of June 26, 2013, the word "married" means that if you are legally married in a state or other jurisdiction that permits opposite or same-sex marriage, your opposite or same-sex spouse will be considered your spouse for all purposes under the Plan regardless of the marriage laws of the state or other jurisdiction in which you currently live. As a result, your married spouse will be considered a spouse for purposes of dependent eligibility, COBRA eligibility and HIPAA special enrollment rights. Also, your married spouse's children will be recognized by the Plan as step-children and they are eligible to be added to the Plan as your covered dependents. The Plan, however, does not provide coverage to domestic partners or any other partnership status that is not fully equivalent to marriage under the laws of the issuing state.**

In addition, effective as of June 26, 2013, the value of your same-sex spouse's coverage under the Plan is not considered taxable income to you for federal tax purposes. Thus, the Plan will not collect any taxes when you pay your dependent premiums for a same-sex spouse.

Section 1: Eligibility

Your eligible dependent natural children, legally adopted children, or children placed with you for adoption or foster care, and dependent stepchildren up to the end of the month in which the child attains age 26 in accordance with the applicable provisions of the Health Care Reform law. Coverage is available, regardless of whether the child is married or unmarried, a student, employed, financially dependent on the participant or residing in your home, or any other factor other than the relationship between the child and the participant. From January 1, 2011 through December 31, 2013, in order to receive coverage under the Plan, adult children (i.e., those who are at least 19 (but below age 26) could not have had access to health insurance coverage through an employer (besides that of another parent's employer) regardless of the costs of that coverage or the benefits that it provides. During this period, eligibility for coverage under a group health plan of the child's spouse's employer constituted "health insurance coverage through an employer."

Effective as of January 1, 2014, the Plan does not exclude adult dependent child(ren) from coverage solely as a result of such child having access to health insurance coverage through an employer (as was previously the case). If, however, your dependent child has other group health insurance including coverage through an employer regardless of whether they have to pay for it, the Plan will generally consider that other coverage to be primary and the Plan's coverage for such child will be secondary in accordance with its Coordination of Benefit ("COB") rules which can be found in this SPD. In addition, as a result of this change, effective as of January 1, 2014, adult dependent children are no longer required to complete an affidavit verifying they do not have employment based coverage elsewhere.

In all instances, if the dependent child is married, coverage, however, will not be extended to the child's spouse or children. Except as otherwise provided by the Plan, if you remain eligible, coverage for your eligible child may continue through the end of the month of his or her 26th birthday.

Your dependents (other than your spouse) over age 19, who are incapable of self-sustaining employment by reason of being mentally retarded and/or physically disabled as such terms are defined by the New York Mental Hygiene Law, will remain eligible for benefits provided they became so incapable prior to their 19th birthday, were covered as Eligible Dependents under the Plan prior to their 19th birthday, and are primarily supported by you. Proof of your Eligible Dependent's mental retardation and/or physical disability must be supplied to the Fund Office by your physician. You must apply for a disabled child's dependent coverage extension and proof of such mental retardation and/or physical handicap no later than 60 days after the date the child would have turned 19, and you must remain covered under the Plan. You will be notified by the Fund if your adult disabled child is found eligible for continuing coverage. Failure to comply with the required proof of your Eligible Dependent's mental retardation and/or physical disability within the timeframe noted above, means your disabled child loses his or her special eligibility status. If you have a dependent child, who becomes mentally retarded or sustains a physical handicap, please immediately contact the Fund Office for details. If, however, your dependent child's disability occurs after reaching age 19, he or she can still qualify under the Fund for health coverage until the last month of his or her 26th birthday.

When you seek to enroll a dependent you must provide all of the following documents if they exist:

- a birth certificate (or court-certified declaration or acknowledgement of paternity);
- a marriage certificate;
- a court-certified judgment of adoption or placement for adoption or foster care;
- in the event you are divorced, a divorce decree;
- a court-certified order of support;
- documentation for any other coverage available to step-children as a result of coverage provided from either biological parent;
- in the case of unmarried Members claiming biological children, documentation of coverage available to the child from the other biological parent must be submitted; and/or
- a notarized affidavit completed by the Member regarding any and all coverage available to any dependent child.

In certain cases these documents may not be sufficient to prove dependency. If you have submitted the required documents and that is the case, the Plan Administrator may request additional documentation of dependency.

The Fund may also require you to submit periodically proof of continued eligibility of any or all of your dependents.

Section 1: Eligibility

Adding a New Dependent (Spouse or Child) to Coverage

If you wish to add a new dependent to coverage you may do so at any time. As described below, special effective dates may apply if you add dependents due to a marriage, the birth, adoption or placement for adoption of a child or foster care. If you wish to enroll a new dependent, call the Fund Office as soon as possible. The Fund Office will advise you of the documents and any other information and materials you need to prove dependency. Generally speaking, effective as of January 1, 2014, you will have 90 days to enroll all new eligible dependents (e.g., spouses and/or children) as of their applicable date (i.e., the date of marriage, the child's birthdate, date of adoption or placement for adoption or foster care, or, in the case of step-children, the date of marriage to the step-child's parent) that establishes their spousal relationship or dependent status with you. If you fail to do so within the applicable 90 day period, dependent coverage will not be available under the Plan for your new spouse or dependent child until the first day of the month following the date in which you provide the Fund Office with a completed Enrollment Form and any other verifying information and documentation requested. If your spouse or dependent children are already enrolled in the Plan, no action is needed in order to maintain their coverage under the Plan.

Your spouse remains a covered dependent unless you are legally divorced. Once divorced, your former spouse will not be eligible for any benefits regardless of coverage stipulations in a divorce decree. You are obliged and responsible for providing the Fund Office with the date of and proof of your divorce. You and your former spouse may be held responsible for any and all claims processed on your former spouse after the date of your divorce.

Newborn Dependent Children (Special Rules for Coverage)

The Plan covers pregnancy and any pregnancy related treatment. In accordance with federal law including without limitation the Newborns' and Mothers' Health Protection Act of 1996, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours after childbirth for any delivery other than a cesarean section. Following a cesarean section delivery, the plan provides, at a minimum, coverage for a hospital stay of at least ninety-six (96) hours. Mother and newborn are automatically eligible for the above hospital lengths of stay following childbirth. If mother or newborn require an extended hospital stay, you must call Empire Blue Cross Blue Shield at 1-800-553-9603 immediately.

If mother or newborn decide to be discharged earlier than either forty-eight (48) hours after childbirth for any delivery other than a cesarean section, or ninety-six (96) hours following a cesarean section, mother or newborn are entitled, upon request made within that time period, to one home care visit. This visit will be made within twenty-four (24) hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits provided by the Plan. It is not subject to the deductible or coinsurance.

In addition to the foregoing, your newborn dependent child will be covered from the date of birth, provided you enroll that newborn dependent child for coverage within 90 days of birth. To do so, please contact the Fund within the applicable 90 day period. Otherwise, the dependent child will be covered from the first 30 days of birth. However, effective as of November 1, 2015, the Plan will cover services rendered to a newborn dependent child for the first 48/96 hours from their date of birth, regardless of whether you timely file the applicable enrollment information within the 90 day period. As such, effective as of November 1, 2015, all claims for services rendered for a newborn child after 48/96 hours from their date of birth will be denied, unless the enrollment (and the required documentation) is timely received by the Fund Office within the 90 day special enrollment period.

Adopted Dependent Children (Special Rules for Coverage)

Your adopted dependent child will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier (but not before you become eligible), provided you enroll that child within 90 days of adoption or placement for adoption (as appropriate). Otherwise, the dependent child will be covered from the date of enrollment. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Section 1: Eligibility

A child who is placed for adoption with you within 90 days after the child was born will be covered from birth provided you enroll that child within 90 days from birth. Otherwise, the dependent child will be covered from the date of enrollment.

However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

If you adopt a newborn child, the child is covered from birth as long as you take custody immediately after the child is released from the hospital and you file an adoption petition with the appropriate state authorities within 90 days after the infant's birth. However, adopted newborns will not be covered from birth if one of the child's biological parents covers the newborn's initial hospital stay, a notice revoking the adoption has been filed or a biological parent revokes consent to the adoption of such newborn.

Special Enrollment Rights Related to Premium Assistance Under Medicaid or a State Children's Health Insurance Program (Special Rules for Coverage)

If you are an active employee and otherwise eligible for coverage under the Plan, and either (i) you or your dependent's coverage under Medicaid or a State Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility for such coverage, or (ii) you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and/or your dependent(s) in the Plan if you request coverage under the Plan within sixty (60) days after the date that Medicaid or CHIP coverage ends or the date you (or your dependent) are determined to be eligible for such assistance. If you qualify for this special enrollment opportunity, coverage under the Plan will be effective beginning on the first day of the first calendar month following the month in which a completed request for enrollment is received by the Fund Office. You are required to pay any additional premium required by the Plan.

Qualified Medical Child Support Order ("QMCSO")

According to federal law, a Qualified Medical Child Support Order ("QMCSO"), is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received and accepted by the Plan as such, and that:

Designates one parent to pay for a child's health plan coverage;

Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;

Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;

States the period for which the QMCSO applies; and

Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires someone who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If the Plan Administrator receives on behalf of a non-custodial child of a Member employed by a Contributing Employer an appropriately completed National Medical Support Notice (promulgated pursuant to Section 401(b) of the Child Support Performance Act of 1998) and such notice meets the requirements set forth above, then the Plan Administrator will deem such notice to be a QMCSO; provided that the Plan, upon receipt of the notice, will not provide benefits (or eligibility for benefits) in addition to benefits (or eligibility) provided immediately prior to receipt of the notice.

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

Section 1: Eligibility

If you are a Member in the Plan, the QMCSO may require the Plan to provide coverage for your dependent child(ren). The Plan will accept a special enrollment of the dependent child(ren) specified by the QMCSO from either you or the custodial parent. Coverage of the dependent child(ren) shall become effective as of the date the enrollment is received by the Plan, and shall be subject to all terms and provisions of the Plan.

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

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

Eligibility for Retirees

Retirees are eligible for those applicable benefits under Section 4 herein. In order to be eligible for benefits, (as described under Section 4 herein), Retirees must also:

- Have fifteen (15) years of Total Credited Service (as defined in the Central Pension Plan),
- Be receiving a pension under the Central Pension Plan, and
- Must have continuous coverage under the Fund for the five (5) years immediately preceding their respective retirement date under the Central Pension Plan.

In addition, Active Members who became totally and permanently disabled and, as a result, lost their coverage under the Fund will again be eligible if they receive a disability pension from the Central Pension Plan and Social Security Disability Award before recovering from the disability.

Eligibility for Active Members Age 65 or Older

If you are actively employed, age 65 or older, and eligible for Social Security, you and your covered dependent spouse, age 65 or older, can cancel or continue to have the Fund pay your claims as primary carrier provided you remain eligible under the rules of the Plan. You and your spouse are also eligible for Medicare coverage. Medicare coverage consists of hospital insurance benefits (called "Part A"), for which you pay no premiums, and supplementary medical insurance ("Part B"), for which you pay monthly premiums; and if you choose, prescription insurance (Part "D") for which a separate monthly premium would be payable.

You and your covered spouse have several coverage options depending upon whether you are actively employed. You and your spouse can continue to have the Fund pay benefits primary, with or without secondary payment by Medicare. You should carefully consider whether or not it is to your advantage to enroll in and pay for Medicare Part B and Part D while you are still working. You and your spouse, separately, have the legal right to decline continued coverage under the Plan and, instead, have Medicare coverage only. In these circumstances, the Plan is not allowed by law to provide coverage for any types of expenses which Medicare covers and pays for first. If you decide to cancel your coverage under the Plan and opt for Medicare coverage only, you lose your right to receive benefits from the Plan as of such cancellation date until you otherwise satisfy the requirements under the subsection entitled "Reinstatement" as discussed in Section 1 herein.

In general, you are eligible to receive Medicare benefits as an Active Member, including Medicare prescription drug coverage if one of these situations applies to you:

- You are age 65 or older,
- You have end stage renal disease (ESRD) (permanent kidney failure requiring dialysis or transplant).

Section 1: Eligibility

WHEN COVERAGE ENDS

Termination of Benefits

Unless otherwise specified by the Board, generally, the effective date of your termination of coverage will be the earliest of the following dates:

You failed to meet the continuing eligibility requirements

The later of: the last day of the month following the month in which you terminate Covered Employment (including retirement), or the date that your Contributing Employer stops making contributions to the Plan,

The last day of the month following the calendar quarter in which you fail to work at least 400 hours,

You cease to make required contributions, if any, to the Plan,

The Plan or the Fund no longer provides coverage to the class of persons of which you or your dependents are member, and/or the effective date of the termination of the Fund or Plan.

Coverage for your Eligible Dependent(s) will end on the last day of either: the month in which your own coverage ends or the month in which your Eligible Dependent(s) no longer meets the definition of an Eligible Dependent under the Plan.

Dependent coverage for your spouse or Eligible Dependent children may continue until the last day of the twelfth (12th) month after your date of death; provided that your spouse or Eligible Dependent children continue to timely pay all applicable premiums required under the Plan.

Your spouse's eligibility ends on the last day of the month in which your divorce occurs.

You and your spouse are obligated to contact and inform the Fund Office in writing of such divorce. If you fail to inform the Fund Office of such divorce, the Fund may hold you and your former spouse responsible for the costs associated with extending coverage to your spouse after your divorce. In addition, the Trustees reserve the right to terminate yours and your remaining dependents' Fund coverage for failure to notify the Fund of such divorce.

In addition, the Board of Trustees reserves the right, in its sole and absolute discretion, to amend or terminate the Plan and/or Fund, in whole or in part, at any time. If such an amendment or termination occurs, your ability to participate in, and to receive benefits under, the Plan may change or terminate. Under no circumstances will any claim or right to benefits under the Plan become vested or nonforfeitable. Furthermore, nothing in this SPD creates an entitlement to retiree health coverage for any retiring Member or such Member's Eligible Dependents.

You and your Eligible Dependent(s) have the legal right to continue benefit Fund coverage following certain "qualifying events" that would otherwise result in a loss of coverage. Please refer to the subsection entitled, "COBRA CONTINUATION COVERAGE" as set forth under Section 1 herein.

Termination of Healthcare Coverage for Cause, including Fraud or Intentional Misrepresentation

The Plan reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded (within the meaning of Affordable Care Act) retroactively (as opposed to prospectively) except in the circumstances permitted by law, such as the failure to pay premiums or the commission of fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Plan administrator or its delegates) by you, your covered dependent(s), or someone seeking coverage on your behalf. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 day notice. Failure to inform the Fund Office that you or your dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation.

Special Circumstances

Special rules, set forth below, apply if you let your coverage lapse while you are on Family and/or Medical Leave or Leave for Military Service.

Section 1: Eligibility

Family and Medical Leaves of Absence

The Family and Medical Leave Act (“FMLA”) allows you to take up to 12 weeks of unpaid leave during any 12month period due to:

**the birth, adoption, or placement with you for adoption of a child;
to provide care for a spouse, child, or parent who is seriously ill; or
your own serious illness.**

Effective as of January 16, 2009, you may also be entitled to up to a maximum of 12 weeks of unpaid leave because of any qualifying exigency (as defined in Department of Labor Regulations) arising out of the fact that your spouse, son, daughter or parent is on active duty or has been notified of an impending call to active duty status, in support of a contingency operation. (If you believe you are entitled to leave due to a qualifying exigency, you should contact your Contributing Employer.) In addition, you may be entitled to up to 26 weeks during a 12month period to take care of a service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious illness or injuries as a result of his or her service.

During your leave, your medical coverage and other benefits offered through the Fund will continue, and your Contributing Employer is still required to contribute on your behalf. You are generally eligible for a leave under the FMLA if you:

**have worked for the same Contributing Employer for at least 12 months;
have worked at least 1,250 hours over the previous 12 months; and
work at a location where at least 50 employees are employed by the Contributing Employer within 75 miles.**

The Fund will maintain the employee’s eligibility status until the end of the leave, provided the Contributing Employer properly grants the leave under the FMLA and the Contributing Employer makes the required notification to the Fund. Of course, any changes in the Plan’s terms, rules or practices that go into effect while you are away on leave apply to you and your dependents, the same as to active employees and their dependents. Call your Contributing Employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

Leaves of Absence for Military Service

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

If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you and your dependents at your own expense for the lesser of: 1) 24 months or, 2) the period of qualified military service (i.e., generally the period beginning on the date that your qualified military absence begins and ending on the date in which you fail to apply for, or return to, a position of Covered Employment with your Contributing Employer). This continuation right operates in the same way as COBRA. See the subsection entitled “Continuation of Coverage Through COBRA” set forth later in this SPD for a full explanation of the COBRA Continuation Coverage provisions, which will allow you to continue your medical and dental coverage. In addition, your dependent(s) may be eligible for health care coverage under the military’s health care program known as TRICARE. The Fund will coordinate coverage with TRICARE. In general, if you or an Eligible Dependent are covered by the Plan and TRICARE, the Plan pays first and TRICARE pays second.

When you return to work with your Contributing Employer after receiving an “honorable discharge” (as such term is defined under USERRA) from qualified military service, your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to Covered Employment within:

**ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days;
or fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or
at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.**

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two (2) years.

Section 1: Eligibility

Call your Contributing Employer if you have questions regarding military service leave. Call the Fund Office if you have questions regarding coverage during such leave.

Reinstatement of Coverage After Leaves of Absence

If your coverage ends while you are on an approved leave of absence for family, medical or military leave, your coverage will be reinstated on the day you return to Covered Employment (see the subsection above entitled “Military Leave” for more information about the required return dates), subject to all accumulated overall and annual plan benefit maximums that were incurred prior to the leave of absence.

Any period pursuant to a leave of absence under the provisions of the FMLA or USERRA shall not be counted as a break in coverage.

90 Day Extension of Benefits for Disability (Active Members and their Eligible Dependents)

If any covered persons are disabled at the time their eligibility terminates, as determined by the Board (in its sole and absolute discretion) they will remain eligible for benefits under the same terms and conditions currently available under the Plan at the time of such disability, for the disabling condition only, for 90 days or until recovery from the disability occurs, if earlier. In order to receive these benefits, you must notify the Fund Office that you are disabled (and submit the physician’s statement to the Fund Office) within 60 days of such physician’s determination. The Fund Office will review the documentation that you submit and determine whether you are disabled. The Fund may require that you visit an independent physician to verify your disability. If the Fund Office finds you to be disabled, your coverage will be reinstated for up to 90 days retroactive to the date your coverage otherwise would have terminated. If your disability continues beyond the 90 day period, you may have a right to continue coverage under COBRA; see the subsection entitled *Continuation of Coverage through COBRA* under Section 1 herein. In this regard, the maximum 90 day continuation period under the Plan will be considered part of the COBRA benefit.

If you return to work before the maximum 90 day continuation period has elapsed and then become disabled again due to the same or a related disability within twelve (12) months of the date of the commencement of the first 90 day period, the recurrent disability will be treated as a continuation of the prior disability. This means coverage continues for the balance of the original 90 day period. However, if you become temporarily disabled due to an unrelated condition, or for the same or a related disability after twelve (12) months of the date of the commencement of the first 90 day period, you will be eligible for a new 90 day continuation period with regard to the second disability.

Extension of Benefits for Total and Permanent Disability (Active Member Only)

If a Member, who is actively working, becomes totally and permanently disabled and not eligible for Medicare at the time eligibility terminates, the Member will remain eligible for benefits for the disabling condition for 29 months, or until the Member becomes eligible for Medicare, if earlier. This applies only to Members with a total and permanent disability, with a Social Security Disability Award as evidence. Accordingly, you may be eligible for a continued disability benefit under the Plan if you also qualify for Social Security disability payments. In order to receive these benefits, you must notify the Fund Office that you are temporarily or permanently disabled (and submit the physician’s statement to the Fund Office) within 60 days of such physician’s determination. The Fund Office will review the documentation that you submit and determine whether you are temporarily or permanently disabled. The Fund may require that you visit an independent physician to verify your disability.

Extension of Benefits for Eligible Dependents of Deceased Members

Benefits will continue for the dependents of deceased Members for the first 12 months immediately following the death of such Member’s under the same terms and conditions currently available under the Plan immediately prior to the date of the Member’s death. This extension period will be considered part of the COBRA benefit. After this 12month period, the family has the option to continue COBRA for the next 24 months; see the subsection entitled *Continuation of Coverage Through COBRA* under Section 1 herein.

COBRA CONTINUATION COVERAGE

Section 1: Eligibility

COBRA, a federal law, allows you and your Eligible Dependents to continue health care coverage for a limited period at your own expense under certain circumstances when health care coverage would otherwise end under the terms of the Plan. You do not have to prove that you are in good health to choose COBRA Continuation Coverage, but you do have to meet the Plan's COBRA eligibility requirements and you must apply and pay for such coverage. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly. In addition, the Fund reserves the right to end your COBRA Continuation Coverage retroactively if you are determined to be ineligible for such coverage.

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

Medical coverage (including PPO coverage).

Hospital coverage.

Prescription drug coverage.

Dental coverage.

Vision coverage.

Notwithstanding the above, COBRA Continuation Coverage does not include "loss of time", "accidental death and dismemberment" or "death benefits"

COBRA Eligibility (COBRA Qualifying Events)

For You

COBRA Continuation Coverage is available to you, as a Member, if coverage would otherwise end if:

Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program, or

Your Covered Employment ends for any reason other than gross misconduct.

For Your Dependents

COBRA Continuation Coverage is available to your Eligible Dependents if coverage would otherwise end if:

Your (as the Member) regularly scheduled hours with your Contributing Employer are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.

You (as the Member) end Covered Employment with your Contributing Employer for any reason other than gross misconduct.

You (as the Member) die, get divorced (or your marriage is civilly annulled), or you become entitled to Medicare (Part A or B, or both) and drop Fund coverage.

Your dependent child ceases to be eligible for Fund coverage.

How COBRA Continuation Coverage Works

Under COBRA, in order to have a right to elect COBRA Continuation Coverage after your divorce, a child ceasing to be a "dependent child" under the Plan, or if you become disabled (or are no longer disabled) as determined by the Social Security Administration, you (or your family member) are responsible for notifying the Fund Office of these qualifying events. To this end, you (or your family member) must notify the Fund Office in writing of any of these qualifying events no later than 60 days after the event occurs or 60 days after the date coverage would have been lost under the Plan because of that event, whichever is later ("60 Day Qualifying Event Notice"). That notice should be sent to:

Health and Benefit Trust Fund of the International Union of Operating Engineers

Local 94-94A-94B, AFL-CIO

Commercial Division

337 West 44th Street

New York, NY 10036

(212) 541-9880

The Fund Office will then send you information about COBRA Continuation Coverage.

Section 1: Eligibility

IF A 60 DAY QUALIFYING EVENT NOTICE IS NOT RECEIVED BY THE FUND ADMINISTRATOR BEFORE THE END OF THAT 60 DAY PERIOD, THE AFFECTED SPOUSE OR DEPENDENT WILL NOT BE ENTITLED TO CHOOSE COBRA CONTINUATION COVERAGE.

Your Contributing Employer must notify the Fund Office within 30 days of your death, termination of Covered Employment, reduction in hours, retirement, or entitlement to Medicare. Once notified by your Contributing Employer of any of these qualifying events, the Fund Office will send you a COBRA Continuation Coverage notice within 30 days. However, you or your family must also notify the Fund Office in writing if any such event occurs within 60 days after the date that coverage would be lost because of that qualifying event in order to avoid confusion over the status of your health care in the event there is a delay or oversight by your Contributing Employer in providing that notification to the Fund Office.

How to Elect COBRA Continuation Coverage

When your Covered Employment terminates or your hours are reduced by your Contributing Employer so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, became entitled to Medicare (and dropped Fund coverage), or that your dependent child loses Eligible Dependent status, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms they need to elect COBRA Continuation Coverage.

Under the law, you and/or your covered dependents will then have only 60 days from the later of: the date coverage is lost or the date you or they receive that notice of your rights to elect COBRA Continuation Coverage. In order for your election to be timely and valid, you must send the completed election form to the Fund Office within that 60 day period.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN THAT 60 DAY PERIOD, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE (COBRA OR OTHERWISE) FROM THIS PLAN AFTER COVERAGE ENDS UNDER THE PLAN.

COBRA Continuation Coverage may be elected for some members of the family and not others. In addition, one or more Eligible Dependents may elect COBRA Continuation Coverage even if the employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event (except in certain cases of added dependents, see page 7-8. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her. However, dependent children have an independent right to elect COBRA Continuation Coverage if the parent does not elect coverage for the child. This means that each Eligible Dependent can decide whether or not to continue coverage under COBRA.

The COBRA Continuation Coverage That Will Be Provided

If you or your Eligible Dependents choose COBRA Continuation Coverage, you and/or they will be entitled to the same health coverage that you or they had when the qualifying event occurred that caused your health coverage under the Plan to end, but you or they must pay for such coverage. See the subsection below entitled the “Paying for COBRA Continuation Coverage” for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage

The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA Continuation Coverage will be payable monthly on an after-tax basis. The Plan charges the full cost of coverage for similarly situated active employees and families, plus an additional 2% (for a total charge of 102% and up to a total charge of 150% for an 11 month disability extension). The COBRA Continuation Coverage charge is different in cases of extended COBRA Continuation Coverage due to disability. See the section entitled COBRA Continuation Coverage in Cases of Social Security Disability” on page 17 for details.

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

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There will be an initial grace period of 45 days from the date COBRA Continuation Coverage was elected to pay the first amounts due (for coverage from the date coverage ends under the Plan through the date of payment). Accordingly, the first payment is due no later than 45 days after the election to receive such coverage. If this payment is not made when due, COBRA Continuation Coverage will not take effect and your plan coverage will end (and cannot be reinstated). After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. If payment of the amounts due is not made by the end of the applicable 30 day grace period, your COBRA Continuation Coverage will terminate as of the end of the last month for which you timely paid and, thereafter, cannot be reinstated.

COBRA Continuation Coverage May Continue For:	If the Following Event Occurs AND Coverage is Lost:	Maximum Length of COBRA Continuation Coverage:
You and Your Eligible Dependents	Your Covered Employment ends (for example, you resign) for any reason except gross misconduct. Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.	18 months (29 months if you or your Eligible Dependent is deemed totally and permanently disabled under Social Security*) from the date of the loss of coverage. 24 months if you go on leave under qualified military service as defined under USERRA.**
Your Eligible Dependents (Spouse and Dependent Children)	You die. You are divorced (or your marriage is civilly annulled). You become entitled to Medicare (and drop Fund coverage). Your child(ren) no longer qualifies as an Eligible Dependent under the Plan.	36 months from the date of the loss of coverage or Medicare entitlement.

* For more information, see the subsection entitled "COBRA Continuation Coverage in Cases of Social Security Disability" on page 17.

** For more information, see the subsection entitled "Leaves of Absence for Military Service" on page 12-13.

Duration of COBRA Continuation Coverage

Your COBRA Continuation Coverage can continue for up to 18, 29, or 36 months depending on the COBRA qualifying event. See the subsection entitled "Special COBRA Extension Coverage" section below for information on the limited circumstances in which COBRA Continuation Coverage can continue beyond these time periods.

The COBRA Continuation Coverage period begins on the date of loss of coverage (rather than on the date of the qualifying event).

18 Months

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

Your reduction in hours.

Your change from active to inactive work status due to your:

- Resignation.
- Discharge (except for discharge for gross misconduct).
- Disability.
- Strike.
- Layoff.

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- Leave of absence (except for leave under the Family and Medical Leave Act (FMLA)).
- Retirement.

29 Months

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

36 Months

COBRA health coverage for your Eligible Dependents can continue for up to a total of 36 months from the date of the loss of coverage due to the occurrence of any one of the following COBRA qualifying events:

Your death.

Your divorce.

You become entitled to Medicare.

Your dependent child is no longer an Eligible Dependent under the Plan's rules.

COBRA Continuation Coverage in Cases of Social Security Disability

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

The disability occurred on or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage.

The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.

The Fund Office must be notified by you or by the disabled covered person or another family member that the determination was issued:

- No later than 60 days after it was issued; and
- Before the 18 month COBRA Continuation Coverage period ends.

This extended period of COBRA Continuation Coverage can continue until the earlier of:

The last day of the month that begins 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled.

The end of 29 months from the date of the loss of coverage due to the COBRA qualifying event.

See also the subsection entitled "Extension of Benefits for Disability" on page 13 for information on special extension coverage for disability.

Cost of COBRA Continuation Coverage in Cases of Social Security Disability

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

Acquiring or Enrolling a New Spouse or Dependent Children (Newborn or Adopted) while Covered by COBRA

Qualified COBRA beneficiaries are entitled to exercise the same rights to enroll dependents under the Plan as are similarly situated active employees who have not had a qualifying event. Additionally, if you acquire a new dependent through

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marriage, birth, adoption or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your initial COBRA Continuation Coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five (5) months of COBRA Continuation Coverage. However, your new spouse will not be deemed a “qualifying beneficiary” whereas your newly born or adopted dependent children will be deemed qualified beneficiaries for purposes of extending the initial COBRA period up to a 29 or 36 month period in the event of a second qualifying event. To enroll your new dependent for coverage for the balance of your initial COBRA Continuation Coverage period, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover a new dependent.

As indicated above, if COBRA Continuation Coverage ceases for you before the end of the maximum 18, 29, or 36-month COBRA Continuation Coverage period, COBRA Continuation Coverage also will end for your newly added spouse since he or she is not deemed a qualified beneficiary for this purpose. However, COBRA Continuation Coverage can continue for your newly added newborn child, adopted child or child placed with the employee for adoption until the end of the maximum COBRA Continuation Coverage period if the required premiums are paid on time. Check with the Fund Office for more details on how long COBRA Continuation Coverage can last for these dependent children under these circumstances.

Multiple Qualifying Events while Covered by COBRA

If, during an 18 month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of Covered Employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a covered child ceases to be an Eligible Dependent child under the Plan, the maximum COBRA Continuation Coverage period for the affected spouse and/or child may be extended to 36 months from the date of the initial loss of coverage due to your termination of Covered Employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

As indicated above, this extended period of COBRA Continuation Coverage is not available to anyone who became your spouse during the initial 18 month period of COBRA Continuation Coverage. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the Member) during the 18 month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your Covered Employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of disability). As a result, if you experience a reduction in hours followed by termination of Covered Employment, the termination of Covered Employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the loss of coverage due to the initial qualifying event.

Medicare and Second Qualifying Events

If you (the Member) become entitled to Medicare less than 18 months before experiencing a qualifying event that is termination of Covered Employment or reduction in hours, COBRA Continuation Coverage for your qualified beneficiaries (e.g., spouse and/or dependent children) shall last until the later of: (i) 36 months after the date you became entitled to Medicare, or (ii) 18 months (or 29 months if there is a disability extension) after the date of termination or reduction in hours of Covered Employment. Accordingly, your qualified beneficiary may be entitled to COBRA Continuation Coverage for a 36 month period beginning on the date you became entitled to Medicare. Please also refer to Section 4 herein for a discussion on the various benefits provided to individuals who are Retirees and meet the applicable eligibility requirements set forth in Section 1 of this SPD. If you lose coverage as a Retiree, you will not be eligible for COBRA Continuation Coverage.

When COBRA Continuation Coverage May Be Cut Short

Once COBRA Continuation Coverage has been elected, it may be cut short before the end of the applicable continuation coverage period (or the Special COBRA Extension Period) on the occurrence of any of the following events:

The premium for coverage is not paid within 30 days of the due date (except your initial payment).

All Fund group health plans are terminated.

The date, after the date of the COBRA election, on which you or your Eligible Dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have.

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The date, after the date of the COBRA election, on which you or your Eligible Dependent(s) first become entitled to Medicare (Part A, B, or both) (usually age 65).

COBRA Continuation Coverage has been extended for up to 29 months due to disability and there has been a final determination that the COBRA recipient is no longer disabled. The COBRA recipient must notify the Fund Office within 30 days of any such determination.

When COBRA Continuation Coverage Ends

If your COBRA Continuation Coverage is not cut short due to one of the above listed events, your COBRA Continuation Coverage will end on the latter of the date that:

The applicable maximum COBRA period (18, 29, or 36 months) ends, or

Your Special COBRA Extension Coverage ends (see page 11 for more details)

If COBRA Continuation Coverage is terminated prior to end of the otherwise applicable coverage period, you and/or your dependents will be notified. Once COBRA Continuation Coverage terminates for any reason, it cannot be reinstated.

Confirmation of Coverage to Covered Providers

- Under certain circumstances, federal rules require the Fund to inform your Covered Providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances: If a health care provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA Continuation Coverage during the 60 day election period; then the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during that election period.
- If, after you have elected COBRA Continuation Coverage, a health care provider requests confirmation of COBRA Continuation Coverage for a period for which the Fund Office has not yet received payment during the 45 day period for payment of the initial premium or during any 30 day grace period for subsequent premiums, then the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA Continuation Coverage rights during such periods.

Other Coverage Options – the Health Insurance Marketplace

Instead of enrolling in COBRA Continuation Coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage.

You should compare your other coverage options with COBRA Continuation Coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA Continuation Coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

As mentioned above, coverage through the Health Insurance Marketplace may cost less than COBRA Continuation Coverage. Being offered COBRA Continuation Coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

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When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA Continuation Coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA Continuation Coverage?

If you sign up for COBRA Continuation Coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA Continuation Coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though if you terminate your COBRA Continuation Coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA Continuation Coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA Continuation Coverage, you cannot switch to COBRA continuation coverage under any circumstances.

What factors should I consider when choosing COBRA versus other continuation coverage options?

You may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you’re currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance Payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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Special Note for TAA Eligible Individuals

The Trade Adjustment Assistance Reform Act of 2002 (“TAA”) created a new tax credit for certain individuals who become eligible for trade adjustment assistance (“TAA Eligible Individuals”). Under the applicable provisions of the TAA, TAA Eligible Individuals may either take a tax credit or get advance payment of 65% of the premiums paid for qualified health insurance, including COBRA Continuation Coverage. This tax credit is referred to as the Health Coverage Tax Credit and is administered by the Internal Revenue Service. The advance credit option is available effective August 1, 2003.

TAA Eligible Individuals who did not previously elect COBRA Continuation Coverage during the original 60 day COBRA election period related to a TAA—related loss of coverage may elect COBRA continuation Coverage during a second 60 day election period. This second 60 day election period begins on the first day of the month in which he or she is determined to be a TAA Eligible Individual, provided that such election may not be made later than six (6) months after the date of the TAA—related loss of coverage. TAA Eligible Individuals may elect COBRA Continuation Coverage for themselves and their eligible family members. Any COBRA Continuation Coverage elected will begin with the first day of the second 60 day election period, and not on the date that coverage was originally lost. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether such individual has a 63 day break in coverage under HIPAA.

If you have questions about these tax provisions under the TAA or you are not sure whether you are a TAA Eligible Individual, contact the Health Care Tax Credit Customer Contract Center toll-free at 1(866) 628-4282. TTD/TTY callers may call toll-free at 1(866) 626-4282. More information about the TAA is also available at http://www.doleta.gov/tradeact/2002act_index.cfm.

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CERTIFICATE OF CREDITABLE COVERAGE

When your Fund coverage ends, you and/or your Eligible Dependents are entitled under HIPAA, and will be provided with, a "Certificate of Creditable Coverage." In general, this certificate indicates the period of time you and/or your dependents were covered under the Fund (including COBRA Continuation Coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA Continuation Coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion periods for pre-existing conditions that may apply to you and/or your dependents under the new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under the Plan (including under COBRA Continuation Coverage), and certain additional information that is required by law.

The Certificate of Creditable Coverage will be provided to you after the Fund knows or has reason to know that coverage (including COBRA Continuation Coverage) for you and/or your covered dependent(s) has ended. The Certificate of Creditable Coverage will also be provided:

- on your request, within 24 months after your Fund coverage ends,
- when you are entitled to elect COBRA Continuation Coverage,
- when your coverage terminates, even if you are not entitled to COBRA Continuation Coverage, or
- when your COBRA Continuation Coverage ends.

Furthermore, if the individual enrolls in a different plan, he or she may authorize that plan to request a Certificate of Creditable Coverage from the Plan. In order to obtain a Certificate of Creditable Coverage, the Member, beneficiary dependent or authorized designee should call (212) 541-9880, or write to:

Health and Benefit Trust Fund of the
I.U.O.E. Local 94-94A-94B, AFL-CIO
School Division
337 West 44th Street
New York, NY 10036

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GENERAL EXCLUSIONS

Benefits are not payable for the following:

1. Occupational accidents, injuries or sickness covered by any Workers' Compensation statute or similar legislation.
2. Services provided in or by a hospital operated by federal, state or city agency or corporations directly connected with a federal, state or city agency.
3. Costs not actually incurred and paid for by you or your Eligible Dependent, or services for which no charge is incurred.
4. Amounts for which you are not legally liable in the absence of coverage by the Fund.
5. Services beyond the scope of the license of the person performing them or the establishment at which such services are performed.
6. Services not in accordance with accepted standards of medical practice.
7. Services, supplies, and treatment not prescribed as Medically Necessary by a Licensed Physician.
8. Charges incurred on account of war, declared or undeclared, including armed aggression.
9. Costs incurred which are or should be covered by mandatory no-fault automobile insurance.
10. Costs incurred for injuries or disability covered by negligence or wrongdoing with respect to which monies are recovered or recoverable in a third party claim, lawsuit or settlement.
11. Cosmetic Surgery.
12. Services rendered by an immediate family member.
13. Special diets and/or foods or diet supplements.
14. The entire claim if any portion thereof has been altered with the intent to defraud the Fund for any purpose, such as obtaining eligibility or increased payments.
15. Treatment of temporomandibular joint (TMJ) disorders.
16. Biofeedback.
17. Suicide or intentionally self-inflicted injuries, other than those injuries resulting from an act of domestic violence or attempted suicide which are attributable to a diagnosed mental health condition. Accordingly, injuries that result from acts of domestic violence or attempted suicides which are attributable to diagnosed mental conditions are covered under the Fund.

Section 2: PPO Benefits

PPO BENEFITS AVAILABLE ONLY FOR ACTIVE MEMBERS AND THEIR ELIGIBLE DEPENDENTS

As discussed above in Section 1, the Fund offers medical, health care, and hospitalization benefits to Active Members and their Eligible Dependents through an insurance agreement entered into between the Fund and Empire Blue Cross Blue Shield. Under this agreement, these benefits are available through Empire Blue Cross Blue Shield's PPO, which is a network of licensed physicians, health care providers, laboratories, and health care facilities, who have agreed to offer their respective medical services according to contractual reimbursement levels negotiated by Empire Blue Cross Blue Shield. These health care providers and services are generally referred to as "In-Network" providers and/or services. However, you also have an opportunity to receive health care for most of the covered services offered under the PPO from providers, who do not participate in Empire Blue Cross Blue Shield's PPO. These health care providers and/or services are generally referred to as "Out-of-Network" providers and/or services. Accordingly, Empire Blue Cross Blue Shield's PPO provides access to great coverage, flexibility and all the advantages of quality care. The medical, health care, and hospital benefits (In-Network and Out-of-Network) available under the PPO are fully described in the Empire Blue Cross Blue Shield's Certificate of Insurance Booklet ("PPO Booklet"), a copy of which is attached as Appendix A to this SPD. The Fund first offered the PPO to School Division Members on September 1, 2004.

The PPO Booklet explains:

what health care and hospitalization services (In-Network and Out-of-Network) are available under the PPO;
how to access such services;
your costs including without limitation the applicable Deductibles, Co-insurances, Co-Payments, and/or an annual plan benefit maximums for such services; and
how Empire Blue Cross Blue Shield can assist you to make the most of these benefits.

The Fund is providing you with a copy of the PPO Booklet to give you an overview of the medical, health care, and hospitalization benefits offered under the Plan. The PPO benefits described therein, however, are subject to the terms, conditions, limitations and exclusions of the contract between Empire Blue Cross Blue Shield and the Fund. To the extent that there is any conflict between these documents, the official contract between Empire Blue Cross Blue Shield and the Fund will control. In addition, please note that certain information is not addressed in the PPO Booklet but rather in this SPD. For example, this SPD contains the Fund's rules including without limitation those that govern your eligibility to participate in the Plan, when you (or your dependent) loses coverage under the Plan, your (or your dependent's) rights to continue coverage under COBRA, coordinating the payment of benefits under this Plan with other sources of coverage, how to file claims and appeals for benefits, etc. To the extent that there is any conflict between these documents with regard to these rules, the SPD will control. This SPD, together with the PPO Booklet constitutes the Fund's SPD as required by ERISA.

If you require information regarding the PPO network including the most current list of participating providers you may call Empire Blue Cross Blue Shield's Member Services at (800) 553-9603 or visit its website at: www.empireblue.com. In addition, you may call the Fund Office at (212) 541-9880 or visit the Local 94 website at <http://www.local94.com>.

Section 3: Fund-Office Administered Benefits

FUND-OFFICE ADMINISTERED BENEFITS

In addition to the PPO benefits (In-Network and/or Out-of-Network) already referred to in Section 2 herein and fully described in the PPO Booklet, the Fund offers additional benefits to cover some services that are not included in the PPO, as well as to provide benefits in the event of your loss of time from work or in the event of your death.

Level of Coverage

Fund-Office Administered Benefits are not subject to an annual Deductible. The Fund has established a Scheduled Allowance for each benefit. If your physician charges more than the Plan's Scheduled Allowance, you will be responsible for the excess.

Fund-Office Administered Benefits for Active Members, Retirees and Their Eligible Dependents

For Active Members, Retirees and their Eligible Dependents, the Fund-Office Administered Benefits are limited to:

Annual Physical Examinations (PEMG only), (Available Only for Active Members and Eligible Dependents)
Infertility Prescription Drugs (For medical services pertaining to infertility please refer to the Empire Blue Cross Blue Shield Appendices) (Available Only for Active Members and their Eligible Spouse)
Eye Care, (Available Only for Active Members and Eligible Dependents)
Hearing Aids (you may also use any participating provider under Empire Blue Cross Blue Shield's HearUSA), (Available Only for Active Members and Eligible Dependents)
Loss of Time Benefits (available only for Active Members),
Death Benefits (available only for Active Members and Retirees), and/or
Accidental Death and Dismemberment Benefits (available only for Active Members)
Medicare Related Premium Reimbursement (Available Only for eligible Retirees and their eligible Spouse) (Please refer to Section 4 Retiree Benefits for further details)

Each of the Fund-Office Administered Benefits available for Active Members and Retirees as well as their Eligible Dependents is described below.

Annual Physical Examination – (Available Only for Active Members and their Eligible Dependents)

The annual physical examination benefit is payable once per Calendar Year per person.

The Fund has an agreement with PEMG to accept the Plan's Scheduled Allowance as payment in full. You may also use your Empire Blue Cross Blue Shield benefits for these services, subject to Deductible, Co-insurance and/or Co-payments.

You may contact PEMG directly to arrange for your annual physical examination, or you may contact any physician of your choice. Please call (800) 811-7364 in order to schedule an annual physical examination with PEMG at any of their following two (2) locations:

Nassau 380 South Broadway
Hicksville, NY 11801

Manhattan 229 West 36th Street, 10th Floor
New York, NY 10018

When your annual physical examination is performed by PEMG, the Fund's Scheduled Allowance includes any "routine" laboratory and "x-ray" services rendered as part of the Fund's payment for that physical examination.

Section 3: Fund-Office Administered Benefits

Infertility Prescription Drugs – (Available Only for Active Members and their Eligible Spouse)

The Fund provides coverage for artificial insemination and advanced reproductive technologies. Please refer to the Empire Blue Cross Blue Shield appendices for further details. You must submit prescription claims to the Fund Office and the Fund will submit to Empire. It also has been determined that the infertility medical services and related prescription drugs are not deemed to be “essential health benefits” under the Health Care Reform law and, therefore, the annual or lifetime dollar limit prohibitions do not apply to such medical or prescription drug services. In light of that determination and unless formal legislative or regulatory guidance is issued to the contrary, the infertility benefit is limited to the member and spouse for a combined Lifetime Maximum of \$12,500 for medical services and prescription drugs, subject to 20% co-insurance.

Eye Care – (Available Only for Active Members and their Eligible Dependents)

The Fund provides benefits for one (1) eye exam and one lens(es) per calendar year. The Fund’s fee schedule is as follows:

Eye exam - \$20

Lenses - \$50

The Fund presently has an arrangement with three eye-glass networks; General Vision Services (“GVS”), Comprehensive Professional Systems (“CPS”) and Vision Screening that have agreed to accept the Fund’s fee schedule for the selected eye care as payment in full. There is no out-of-pocket expense provided the lenses and frames you select are within the variety of lenses and frames offered under the Fund. Please call the Fund Office or log onto www.local94.com for a list of participating GVS, CPS and Vision Screening locations and phone numbers to call to schedule an appointment.

Effective as of January 1, 2011, the Fund’s lifetime and/or annual dollar limits, if any, will not apply to pediatric vision care (treatment or services of a patient under the age of 19) to the extent that such benefits are determined to be essential health benefits under the Health Care Reform law. Notwithstanding the foregoing, all applicable visit or frequency limitations will remain in effect. Also, it has been determined that lasik surgery is not deemed to be an “essential health benefit” and, therefore, the \$1,000.00 per eye will continue to apply for such benefits, unless formal legislative or regulatory guidance is issued to the contrary.

Hearing Aids– (Available Only for Active Members and their Eligible Dependents)

The Fund provides hearing aid benefits once every three (3) calendar years as follows:

\$700 per ear for the fees charged for the purchase of hearing aids prescribed by a licensed physician.

The \$700 limit on hearing aids per ear was eliminated, effective as of January 1, 2011, to the extent that it is determined that the hearing aid constitutes an “essential health benefit” (i.e., a rehabilitative device) as required under the Health Care Reform law. A prescription from a doctor of medicine (M.D.) is required for purposes of demonstrating whether a hearing aid is an essential health benefit. If a hearing aid is determined by the Plan Administrator to be an essential health benefit, the Plan will cover the reasonable and customary rates for such hearing aid in accordance with the terms set forth in the SPD. Generally speaking, reasonable and customary rates will typically track the Plan’s fee schedule for corresponding in-network devices. Notwithstanding the foregoing, the three year frequency limit will remain in effect for such benefits, regardless of whether a hearing aid is determined to be an “essential” or a “non-essential” health benefit.

You may also use your Empire Blue Cross Blue Shield benefits through HearUSA only for these services. No other vendor is covered under Empire Blue Cross Blue Shield.

Loss of Time Benefits, Off the Job Only – (Available Only for Active Members)

If you are unable to work, due to an Accidental Injury or illness off the job, you will receive a net income of \$100.00 per week for up to 26 weeks. The Fund will pay both your share and the Contributing Employer’s share of FICA taxes on this income.

This benefit will begin:

On the first day of disability due to an Accidental Injury, or

On the eighth day of disability due to illness.

Section 3: Fund-Office Administered Benefits

This benefit supplements any New York State disability benefits to which you may be entitled, as provided by law, from your Contributing Employer.

The \$100.00 per week benefit will continue for a maximum of 26 weeks during each period of disability, but for no more than 26 weeks for the same or related disabilities within any period of 52 consecutive weeks.

Successive periods of disability separated by less than two (2) weeks of Covered Employment will be considered as one continuous period of disability unless they are from different and unrelated causes.

In order to receive these benefits, you must be under the continuous care of a Licensed Physician and you must be unable to work. The physician or surgeon who is giving you regular care must certify that you are unable to work.

If you cannot work because of an off-the-job Accidental Injury or illness, notify the Fund Office immediately. If you are unable to notify the Fund Office yourself, have someone else do it for you. The proper claim form will be sent to you for completion by you and your physician.

Pregnancy will be covered as any other off-the-job illness and benefits will be paid in accordance with the above provisions and in accordance with federal and New York State laws and regulations.

Death Benefit – (Available Only for Active Members and Retirees)

If you are an eligible Active Member, your beneficiary will receive a payment of \$25,000.00 upon your death from any cause either on or off the job while eligible for this benefit under the Plan. If you are an eligible Retiree, your beneficiary will receive a payment of \$3,000.00 upon your death from any cause while eligible for this benefit under the Plan.

Your coverage for death benefits as an eligible Active Member or a Retiree will be continued if you become totally and permanently disabled while you are eligible for benefits with the Fund and die from causes related to that disability within two (2) years of the date your disability began.

Naming Your Beneficiary

Be sure to complete a beneficiary form (available from the Fund Office or online at www.Local94.com) that designates your beneficiary for your death benefit. You may change your beneficiary at any time.

If you do not name a beneficiary, or if your beneficiary dies before you, or is determined by the Trustees, in their sole and absolute discretion, to be unable, incompetent or unavailable to receive your death benefit, your death benefit will be paid to your estate.

Any attempted assignment or alienation by the beneficiary of your death benefit prior to actual receipt from the Fund will be considered null and void. In such cases, the money will be held by the Trustees for such purposes as they in their sole discretion deem proper.

Your beneficiary for the Death Benefit will also be your beneficiary for the Accidental Death Benefit and the Sick Fund.

Accidental Death and Dismemberment Benefits – (Available Only for Active Members)

The Accidental Death and Dismemberment Benefits provide a benefit to you or your beneficiary if you die as a result of bodily injuries that were sustained in an accident or if you sustained certain bodily Accidental Injuries as the result of an accident. You must be an Active Member to receive this benefit.

Accidental Death

\$25,000.00 will be paid to your beneficiary if you die as a direct and exclusive result of bodily Accidental Injuries sustained in an accident that occurs either on or off the job provided your death occurs within thirteen (13) weeks from the date of the accident.

Section 3: Fund-Office Administered Benefits

Accidental Dismemberment

You will also receive the following if you incur one of the following injuries:

- (1) **\$25,000.00** if you sustain bodily Accidental Injuries that directly and exclusively result in the loss of both hands, both feet, both eyes, one hand and one foot, one hand and one eye, or one foot and one eye within thirteen (13) weeks from the date of the accident that caused the bodily injuries.
- (2) **\$12,500.00** if you sustain bodily Accidental Injuries that directly and exclusively result in the loss of one hand, one foot, or one eye within thirteen (13) weeks from the date of the accident that caused the bodily injuries.
- (3) **\$6,250.00** if you sustain bodily Accidental Injuries that directly and exclusively result in the loss of the thumb and index finger of either hand within thirteen (13) weeks from the date of the accident that caused the bodily injuries.

If two (2) or more covered losses result from the same accident, the Fund will pay the covered loss that provides the largest benefit.

Accidental Death and Dismemberment Benefits cover occupational as well as off-the-job accidents. However, they do not cover death or injuries sustained under the following circumstances:

War or any act incident to war, declared or undeclared;

Operating, riding in, descending or falling from or with any kind of aircraft, except as a passenger, without duties of any kind, on a civilian aircraft flown by a licensed pilot operating within the scope of his or her license;

Bodily or mental infirmity or disease, or medical or surgical treatment thereof;

Service in the military, naval, air forces or other armed services of any country, combination of countries or international organization while such country, combination of countries or international organization is engaged in war, declared or undeclared; or

Participating or engaged in a riot or criminal act of any kind.

Naming Your Beneficiary

Your beneficiary for the Accidental Death Benefit and the Sick Fund will be the same as your Beneficiary for the Death Benefit (see the previous section for further details).

MEDICARE RELATED PREMIUM REIMBURSEMENT BENEFIT- (Available only for Retirees and their Eligible Spouses)

Effective June 1, 2007 the annual calendar year maximum for the reimbursement of the Medicare Part B and Part D premiums paid by the eligible School Retiree was \$500.00. The benefit reimbursement was for the eligible participants only (not participant's spouses).

Effective January 1, 2010 the annual calendar year maximum for the reimbursement of Medicare Part B and Part D premiums was increased from \$500 to \$1,500 and this benefit was made available for an eligible retiree's spouse. However, the "new" annual calendar year maximum of \$1,500 is not applied on a per person basis, but instead is a combined annual maximum of \$1,500 for the Medicare Part B and Part D premiums paid by the eligible retiree and/or their spouse.

Effective January 1, 2016 the annual calendar year maximum for the Reimbursement of Medicare Related Premiums will now include reimbursement for any Medicare Supplemental, Medicare Advantage and Medicare Plan D program. The annual calendar year maximum for the premiums to be reimbursed is increased from \$1,500 to \$3,000. The "new" annual calendar year maximum of \$3,000 will continue to be a combined annual maximum paid by the eligible retiree and/or their spouse.

In order to be reimbursed for the Medicare Related Premiums that you (or your spouse) have paid during a calendar year, you (and your spouse) must send the Plan proof of such premium payments within one year following the end of the calendar year. You are also required to complete the Medicare Related Premium Reimbursement Form. The form can be downloaded at www.local94.com.

Section 3: Fund-Office Administered Benefits

The following forms of proof are acceptable:

1. If you (or your spouse) have Social Security Income and/or Supplemental Security Income (collectively referred to as (“SSI”), and are qualified for Medicare, the following proof must be submitted:
 - a. Form SSA-1099 Social Security Benefit Statement (this statement can be obtained from your local Social Security Office)

2. If you (or your spouse) do not qualify for SSI, but qualify for Medicare and pay premiums directly, the following proof must be submitted:
 - a. "Proof of Income" Letter or "Proof of Award" Letter from Social Security. You can also request the form online via <http://ssa.gov/onlineservices/>. (It may take up to 30 days for delivery); **and**
 - b. A cancelled check (front and back) and a copy of the quarterly invoice statement (CMS 500) from Social Security Office for the current year; **or**
 - c. Latest bank or credit card statement showing the current premium for Medicare Related Premiums charged against your account (please hide your account number).

Once the Fund Office receives the required proof of payment and the completed Medicare Related Premium Reimbursement Form, it will process your application for the reimbursement of the Medicare related premiums paid, up to the annual calendar year maximum.

Section 4: Retirees' Benefits

RETIREES' BENEFITS

The Death Benefit and the Medicare Related Premium Reimbursement benefit are provided to individuals who are Retirees and meet the eligibility requirements applicable to Retirees as set forth in Section 1 of this SPD.

DEATH BENEFIT

Retirees Only

Retirees of any age are eligible for a Death Benefit in the amount of \$3,000.00.

Naming Your Beneficiary

Be sure to complete a beneficiary form (available from the Fund Office) or online at www.local94.com that designates your beneficiary for your death benefit. You may change your beneficiary at any time.

If you do not name a beneficiary, or if your beneficiary dies before you, or is determined by the Trustees, in their sole and absolute discretion, to be unable, incompetent or unavailable to receive your death benefit, your death benefit will be paid to your estate.

Any attempted assignment or alienation by the beneficiary of your death benefit prior to actual receipt from the Fund will be considered null and void. In such cases, the money will be held by the Trustees for such purposes, as they in their sole discretion deem proper.

No interest will accrue or be paid between the time of death and the time of payment of the benefit.

MEDICARE RELATED PREMIUM REIMBURSEMENT BENEFIT

Effective January 1, 2016 the annual calendar year maximum for the Reimbursement of Medicare Related Premiums will now include reimbursement for any Medicare Supplemental, Medicare Advantage and Medicare Plan D program. The annual calendar year maximum for the premiums to be reimbursed is increased from \$1,500 to \$3,000. The "new" annual calendar year maximum of \$3,000 will continue to be a combined annual maximum paid by the eligible retiree and/or their spouse.

In order to be reimbursed for the Medicare Related Premiums that you (or your spouse) have paid during a calendar year, you (and your spouse) must send the Plan proof of such premium payments within one year following the end of the calendar year. You are also required to complete the Medicare Related Premium Reimbursement Form. The form can be downloaded at www.local94.com.

The following forms of proof are acceptable:

1. If you (or your spouse) have Social Security Income and/or Supplemental Security Income (collectively referred to as "SSI"), and are qualified for Medicare, the following proof must be submitted:
 - a. Form SSA-1099 Social Security Benefit Statement (this statement can be obtained from your local Social Security Office)
2. If you (or your spouse) do not qualify for SSI, but qualify for Medicare and pay premiums directly, the following proof must be submitted:
 - a. "Proof of Income" Letter or "Proof of Award" Letter from Social Security. You can also request the form online via <http://ssa.gov/onlineservices/>. (It may take up to 30 days for delivery); **and**
 - b. A cancelled check (front and back) and a copy of the quarterly invoice statement (CMS 500) from Social Security Office for the current year; **or**
 - c. Latest bank or credit card statement showing the current premium for Medicare Related Premiums charged against your account (please hide your account number).

Once the Fund Office receives the required proof of payment and the completed Medicare Related Premium Reimbursement Form, it will process your application for the reimbursement of the Medicare related premiums paid, up to the annual calendar year maximum.

Section 5: Prescription Drug Benefits

PRESCRIPTION DRUG BENEFITS AVAILABLE ONLY FOR ACTIVE MEMBERS AND THEIR ELIGIBLE DEPENDENTS

Prescription drug benefits offered by the Fund are provided in accordance with a written agreement with CVS/ Caremark. In general, these benefits are available through the following two (2) methods: CVS/Caremark's Mail Service Pharmacy ("Mail Service") and CVS/ Caremark's Retail Service Pharmacy ("Retail Service").

For prescription drugs, there is no Deductible for you to satisfy before you are able to take advantage of the following discounts.

The Plan has implemented a Traditional Generic Step Therapy Program. If you use certain **single source** brand-name drugs before trying a generic medication, your prescription will not be covered and you will need to pay the full cost.

If you use certain **multi-source** brand name drugs and there is a generic brand available, you will be responsible for your regular brand Co-payment as well as the difference in the cost between the applicable brand drug and the generic equivalent.

The Plan has implemented a Specialty Guideline Management Program. This Program supports safe, clinically appropriate, and cost effective use of specialty medications. Specialty medications cannot be purchased at Retail Service. A clinical review is required on all specialty medications.

Specialty Preferred Drug Plan Design

In addition, effective as of October 1, 2013, the Plan has implemented a specialty preferred drug plan design program in the TNF Inhibitor Classes (Rheumatoid Arthritis, Crohn's Disease and Psoriasis), and for the treatment of Multiple Sclerosis. Specifically, this program will steer utilization to the lowest cost preferred drugs in the biologic class for such specialty prescription drugs while offering appropriate, safe choices for patients and physicians. As a result, under this program, the applicable lowest cost preferred drug in the biological class will be substituted for the brand-name drug prescribed by your doctor, unless your doctor confirms with medical necessity, that the brand name prescribed medicine is required to be taken due to medically necessity. However, any participant who was currently receiving one of the above-mentioned specialty drugs prior to October 1, 2013 will be deemed to be grandfathered and, as a result, this program will not apply to those participants (instead, the Plan's prior rules with regard to such specialty drugs will apply to all grandfathered participants for this specific benefit purpose). Accordingly, effective October 1, 2013, the only "new to therapy" participants will be subject to the new specialty preferred drug plan design and, as such, will be required to go through the Plan's step therapy procedures outlined above. Please note that going forward there may be additional therapeutic classes incorporated into this program as they are made available and will include: Hepatitis C, Pulmonary Arterial Hypertension, Anemia and IVIG (Intravenous Immunoglobulin).

Prior Authorization for Certain Compound Prescription Drugs

Effective as of March 1, 2015, prior authorization is required for compound medications available under the Plan. Generally speaking, a compound medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication to fit the unique need of a patient.

As a result of this change, those of you who are prescribed compound drugs with a dollar threshold of \$300.00 are required to receive prior-authorization from the Plan in order for such drugs to be covered under the Plan. Your physician can request prior authorization by contacting the Plan's prescription drug benefit manager, CVS/Caremark, at 1-800-294-5979. If approved, you can receive the prescribed compound drug at the applicable co-payment required under the Plan. If you are not approved, your treating physician will have to prescribe an alternative, non-compound prescription drug. Otherwise, you will have to pay for the entire cost of the unauthorized compound prescription drug.

Section 5: Prescription Drug Benefits

Topical Analgesics

Effective as of June 1, 2015 select topical analgesics are excluded from coverage under the Plan. Generally speaking, this change impacts those topical analgesics that are used to address temporary relief of minor aches and muscle pains that come with:

- Arthritis
- Simple backache
- Strains
- Muscle soreness and stiffness.

If you have any questions or concerns about the Plan's prescription drug benefits, please call Caremark Connect at 1-800-237-2767 or visit Caremark.com/specialty.

MAINTENANCE DRUGS (MAIL-SERVICE/MAINTENANCE CHOICE)

A "maintenance" prescription is a prescription drug typically taken on a regular basis to treat a chronic condition and is limited to two (2) fills at a retail pharmacy before Mail Service must be utilized. Some examples of maintenance drugs are for Diabetes, Heart problems (cholesterol), or blood pressure medications. The Plan will not cover any refills of a maintenance prescription drug by Retail Service after the second prescription of such maintenance prescription drug is filled through Retail Service. If you are currently taking a maintenance prescription, you must use one of the following options below to receive up to a 90 day supply of covered medication:

- (1) At a CVS pharmacy location you may:
 - Pick up a 90 day supply of medication directly from the pharmacy at a time that is convenient
 - Enjoy same-day prescription availability
 - Talk face-to-face with a pharmacist
- (2) CVS/Caremark Mail Service Pharmacy you may:
 - Receive a 90 day supply of medication in confidential, tamper-resistant and (when necessary) temperature-controlled packaging
 - Enjoy convenient home delivery
 - Talk to a pharmacist by phone

The cost to you is as follows:

Mail Service – 90 day supply

- » Generics = \$10.00 co-pay.
- » Brand Formulary or Brand Non-Formulary = \$25.00 co-pay.

Specialty Drugs – 20% up to a \$150.00 co-pay

For a Brand Drug with an FDA approved Generic (Multi-Source Brand) Drug available, the participant will be responsible for the Brand Drug co-pay plus the cost differential between the Brand Drug Ingredient cost and the approved Generic Drug Ingredient cost.

For more information, contact CVS/Caremark Customer Service at 1-888-769-9054, or the Fund Office at (212) 541-9880.

NON-MAINTENANCE DRUGS (RETAIL SERVICE)

"Non-maintenance" drugs are medications that are taken for a short-term condition. These medications may be obtained from your local retail service pharmacy. A prescription drug is considered a "maintenance" drug when it has been purchased twice at the pharmacy. The Plan will not cover any refills at a retail pharmacy after the second prescription of any non-maintenance drug is filled.

You may use Retail Service at **any** pharmacy participating in CVS/ Caremark's retail network to purchase up to a 30 day supply of covered prescriptions. CVS/ Caremark's retail network is comprised of other retail pharmacies which are not solely CVS. For a complete listing of these participating pharmacies please visit www.caremark.com.

Section 5: Prescription Drug Benefits

The cost to you is as follows:

Retail – The 30 day prescription co-pay at retail will be:

- » Generics = \$5.00 co-pay.
- » Brand Formulary or Brand Non-Formulary = \$15.00 co-pay.

Specialty Drugs 20% up to a \$50.00 co-pay.

For a Brand Drug with an FDA approved Generic (Multi-Source Brand) Drug available, the participant will be responsible for the Brand Drug co-pay plus the cost differential between the Brand Drug Ingredient cost and the approved Generic Drug Ingredient cost.

Dispensed as Written (“DAW”) Penalty

In an effort to keep the Plan’s overall prescription drug costs down and preserve the general plan of benefits available under it, the Plan applies a DAW penalty regarding the reimbursement of covered prescriptions paid by eligible participants (those who satisfy the eligibility requirements under the SPD for such benefit). The DAW penalty will apply if either you or your doctors request a brand-name medicine when a generic equivalent is available. Under this circumstance, you will be responsible for paying the applicable **co-payment*** for the brand name medicine, plus the difference in the Plan’s cost between the brand-name medicine that was dispensed to you and the generic medicine that was available and otherwise could have been dispensed to you. This cost difference (which can range into the hundreds or thousands of dollars) is considered a penalty for not taking the otherwise “generic” medicine.

Effective as of October 1, 2013, there are two (2) different DAW penalties under the Plan – DAW-1 and DAW-2. The first penalty (known as the DAW-1 Penalty) is applied when a generic medicine is available but the pharmacy dispenses the brand name version pursuant to your physician’s request. For example, your physician says you must take Coumadin (an anticoagulant (blood-thinner) medication) to treat heart disease, but there is a generic called Warfarin available for such condition. Under these circumstances, the participant will pay the applicable **co-payment*** for the brand name medicine, plus the difference between the Plan’s cost of such brand name medicine and the generic medicine that was otherwise available to you.

The second penalty (known as the DAW-2 Penalty) is applied when a generic medicine is available but the pharmacy dispenses the brand name version pursuant to your (or your dependent’s) request. Under these circumstances, you will pay the applicable **co-payment*** for the brand name medicine, plus the difference between the Plan’s cost of such brand name medicine and the generic medicine that was otherwise available to you.

When using most pharmacies, including CVS/Caremark Mail Service Pharmacy, a generic medicine, if available, will be substituted for a brand-name medicine unless your doctor indicates “Dispense as Written” (DAW) on the prescription, or you request that only the brand-name medicine be provided.

Notwithstanding the foregoing, the DAW-1 or DAW-2 penalties will not apply if you receive approval from CVS that the brand name prescription medicine is required to be taken due to medical necessity. If it is determined that you are medically required to take a brand-name prescription drug, you will only have to pay the applicable **co-payment*** per prescription. You can request approval by contacting CVS at the following number 1-888-769-9054. Your physician must submit your medical records to CVS to review the request and for approval. If it is not approved, you will have to pay the additional DAW penalty per prescription in order to receive the brand name medicine, or file an appeal with the Plan. If you decide to appeal and it is denied, you will have to pay the additional DAW penalty per prescription in order to receive the brand name medicine.

***Co-payment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.**

Should you have any difficulties at your pharmacy, please have the pharmacist call CVS /Caremark’s Help Desk at 1-888-769-9054. Usually, the situation can be resolved while you are still at the pharmacy.

Section 5: Prescription Drug Benefits

COVERED PRESCRIPTION DRUGS

Federal legend prescription drugs,
Drugs requiring a prescription under the applicable state law,
Insulin syringes,
Injectable insulin, or
Diabetic supplies (lancets, alcohol swabs, test strips).

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

Exclusions

Non-legend drugs other than insulin,
Therapeutic devices or appliances, support garments and other non-medical substances,
Investigational or experimental drugs; including compounded medications for non-FDA approved use
Prescriptions which an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state, or federal program,
Diet Medications
Nutritional Supplements
Contraceptive devices,
Infertility medications (see Section 3 – Fund Office Administered Benefits)
Rogaine (cosmetic use) and Propecia,
Vitamins except prescription pre-natal and except prescription fluoride vitamin for children up to the age of 12, or
Smoking cessation products.

Limitations

The following items will only be covered if pre-authorized, based on medical necessity:
Drugs intended for use in a physician's office or another medical health setting other than home use,
Growth hormones,
Immunization agents, biological sera, blood or blood plasma,
Tretinoin, all dosage forms (retin-a) for age 26 and older,
Contraceptives, or
Amphetamines

Section 6: Sele-Dent Dental Program

LOCAL 94/SELE-DENT DENTAL PROGRAM AVAILABLE ONLY FOR ACTIVE MEMBERS AND THEIR ELIGIBLE DEPENDENTS

DENTAL AND ORTHODONTIA BENEFITS

Necessary dental care is a service or supply that is required to identify or treat a dental condition, disease or injury. The fact that a dentist prescribes or approves a service or supply to be rendered does not make it necessary dental care. The service or supply must be all of the following:

Provided by a dentist, or solely in the case of cleaning or scaling of teeth, performed by a licensed, registered dental hygienist under the supervision and direction of a licensed dentist,
Consistent with the symptoms, diagnosis or treatment of the condition, disease or injury,
Consistent with standards of good dental practice,
Not solely for the patient's or the dentist's convenience, and
The most appropriate supply or level of service that can safely be provided to the patient.

Note: Sele-Dent administers all dental and orthodontia claims for the Plan. As such, all dental and orthodontia claim submissions should be sent directly to:

Sele-Dent, Inc.
One Huntington Quadrangle
Suite 1-S03
Melville, NY 11747

All customer service questions may be directed to Sele-Dent at 1-800-520-3368, Monday thru Friday 8:00 a.m. to 4:00 p.m. In addition, you may also visit Sele-Dent's website at www.Sele-Dent.com.

Note: Dental and orthodontia benefits are not subject to any annual Deductible. For dental benefits, however, there will be an annual dental maximum per covered individual per each calendar year. The dental maximum is an annual maximum of \$2,500 per covered individual per calendar year. The Plan's annual dental maximum will not apply to pediatric dental care (treatment of a patient under the age of 19) to the extent that such benefits are determined to be essential health benefits under the Health Care Reform law. Notwithstanding the foregoing, all applicable visit or frequency limitations will remain in effect.

Note: Orthodontia benefits are available for Eligible Dependent children under the age of 19 only. The orthodontia benefit has a lifetime maximum of \$2,154. These benefits will not reduce the above \$2,500 annual dental maximum per covered individual per each calendar year.

Orthodontia Benefit

Effective January 1, 2017, the Invisalign method for corrective orthodontics (as approved by the American Dental Association) is now a covered treatment under the existing orthodontic lifetime maximum of \$2,154. Please note this is a more expensive method of treatment than traditional orthodontic brackets; therefore the Local 94 Network orthodontists and the Sele-Dent PPO orthodontists do not have to accept the orthodontic lifetime maximum of \$2,154 for the Invisalign treatment as payment in full. However, you now have the option to choose this treatment as a covered benefit with the Plan covering up to \$2,154 of the costs for the Invisalign method. **For this reason, it is important that you confirm with your orthodontist whether they will accept this amount as payment in full for such benefits or if they will charge a higher amount and bill you for the balance.**

Note: All dental service over \$500, all dental implants, and all orthodontia services must be pre-approved by Sele-Dent. Prior approval is necessary even if your dental provider is a participating dental provider in Local 94's Network or Sele-Dent's Network. An approved treatment plan submitted by a dental provider can be used by that provider for one (1) year from the date of the approval; provided that the approved services for the treatment plan shall be limited to the remaining balance of your applicable annual maximum for the calendar year at issue at the time the services are rendered. In addition, your approved treatment plan is subject to your eligibility at the time the services are rendered.

Section 6: Sele-Dent Dental Program

UTILIZING THE LOCAL 94 NETWORK

The Fund has an arrangement with certain dentists (“Local 94 Network”) who have agreed to accept the Plan’s Fee Schedule as payment in full except for dental implants where copayments apply. Please refer to Appendix B at the end of this SPD for a list of the Plan’s Fee Schedule for dental benefits provided under the Plan. Prior to service being rendered, please verify that your dental provider is currently in the Local 94 Network.

To be certain of the applicable fees, if any, for your procedure, you or your dentist’s office may contact the Fund Office at (212) 541-9880 or visit the Fund’s website at <http://www.local94.com>. In addition, you or your dentist’s office may call Sele-Dent at (800) 520-3368 or visit its website at www.Sele-Dent.com.

Dental Implants

NOTE: All dental implants regardless of the cost must be pre-approved by Sele-Dent.

	<u>Local 94’s Fee Schedule effective 1/1/17</u>	<u>Member’s Co-Payment</u>
Surgical placement of implant body: endosteal implant Procedure code D6010	\$600.00	\$600.00
Prefabricated abutment Procedure code D6056 or D6057	\$239.00	\$100.00
Abutment supported porcelain fused to metal crown..... (Predominantly based metal) Procedure code D6059 or D6060	\$437.00	\$100.00

Local 94’s Fee Schedule and the Member’s Co-payment will be considered payment in full when using a Local 94 participating dentist or dental provider.

UTILIZING THE SELE-DENT PPO NETWORK

If you don’t visit a provider in the Local 94 Network, you can visit a dental provider in the Sele-Dent PPO. However, there will be applicable Co-payments for services rendered by dental providers in the Sele-Dent PPO. Please refer to the Appendix C at the end of the SPD for a partial list of the current Co-payments for dental benefits provided under Sele-Dent’s PPO.

If you reside outside the New York Metro area, please call Sele-Dent for a provider near you. Please note that the Schedule of Co-payments may differ based on your location.

If a dentist is a participating dental provider in both the Local 94 Network and the Sele-Dent PPO Network then the participating dental provider will be reimbursed the applicable allowances in accordance with the Plan’s Fee Schedule as payment in full with no out-of-pocket cost to the Member.

If you visit a Sele-Dent dentist for dental implants or orthodontia, you will be responsible for fees in excess of the Local 94 Fee Schedule for these dental services. To locate a provider in the Local 94 Network, please call (212) 541-9880 (8 a.m. to 4 p.m.) or visit our website www.local94.com.

Section 6: Sele-Dent Dental Program

UTILIZING A NON-PARTICIPATING DENTAL PROVIDER

However, a non-participating dental provider (e.g., a dentist that is not in either the Local 94 Network or Sele-Dent's PPO Network) may not accept the Fund's coverage as payment in full. If you choose a non-participating dental provider you will be reimbursed according to the Plan's Fee Schedule. Please refer to Appendix B at the end of this SPD for a list of the Plan's Fee Schedule for dental benefits provided under the Plan. You will be fully responsible for any excess charges over the applicable fees set forth under the Plan's Fee Schedule. To this end, a non-participating provider will bill you directly for all charges over the Fund's Fee Schedule.

If you visit a Sele-Dent dentist for dental implants or orthodontia, you will be responsible for fees in excess of the Local 94 Fee Schedule for these dental services. To locate provider in the Local 94 Network, please call (212) 541-9880 (8 a.m. to 4 p.m.) or visit our website www.local94.com.

DENTAL LIMITATIONS AND EXCLUSIONS

Limitations

Dental work that starts after the termination of coverage is not covered. However, you will continue to be covered, for 90 days after termination of coverage, for dental work that was started before termination of coverage. Surgical implants except where Medically Necessary and in cases where alternative procedures are not recommended. Whether these conditions are satisfied will be determined by the Trustees in their sole and absolute discretion.

Exclusions – Dental and/or Orthodontia Services Not Covered by the Fund

Dental conditions that existed prior to your eligibility for these benefits under the Plan may be covered, but dental work done prior to eligibility is not payable.

Treatment of and appliances for temporomandibular joint (TMJ) syndrome are not covered by the Fund.

Dental benefits are not payable for replacing lost appliances.

Dental benefits are not payable for prosthetic appliances made in connection with periodontal care, unless it replaces a missing tooth.

Cosmetic Dentistry including without limitation laminate, veneers and tooth bleaching.

Orthodontia is not covered for anyone other than dependent children under age 19.

Reimbursement for any services in excess of the applicable frequency limitations specified in the Fund's Schedule of Benefits with regard to either the Local 94 Network or Sele-Dent's PPO Network.

Charges in excess of your annual Maximum Allowance.

Expenses incurred for broken appointments.

Section 7: Important Information

IMPORTANT INFORMATION

The Fund Office is available to help resolve any problem you may have regarding your benefits. All plan documents including without limitation this SPD and the PPO Booklet (copy of which is attached to this SPD as Appendix A) and other related information are available for your review upon request.

PROCEDURES FOR FILING CLAIMS FOR BENEFITS AND APPEALS

This section describes the procedures for filing claims for Plan benefits. 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.

Claims for Benefits

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures including the filing of a claim (where necessary). The claims procedures vary depending on the specific benefit you are requesting. When the procedures require that you file a claim for benefits offered under this Plan, you must submit a completed claim form. In order to file a claim for benefits offered under this Plan, you must follow the Plan's claims procedures which include filing a claim form (where necessary). Please note that the following are not considered claims for such benefits:

Inquiries about the Plan's provisions or eligibility that are unrelated to any specific benefit claim, A request for prior approval of a benefit that does not require prior approval by the Plan, and Presentation of a prescription to be filled a pharmacy that is party of CVS/Caremark's network of participating pharmacies, which exercises no discretion on behalf of the Plan. However, if you believe that your prescription has not been filled by a participating pharmacy in accordance with the terms of the Plan, in whole or in part, you may file a claim using the procedures described herein.

How to Claim Benefits

Generally, you will not need to file a claim form for PPO "In-Network" services you receive. However, when you or your dependents have a claim for an Out-of-Network, please contact Empire Blue Cross Blue Shield at 1-800-553-9603 or by logging on to Empire Blue Cross Blue Shield's website at www.empireblue.com for a claim form. For Fund-Office Administered Benefits provided under the Plan, call the Fund Office at (212) 541-9880 for claim forms, which will be mailed to you upon your request. Requests for claim forms may also be made by logging on to the Fund's website at <http://www.local94.com> or writing to the Fund Office at the following address:

Health and Benefit Trust Fund of the
I.U.O.E. Local 94-94A-94B, AFL-CIO
School Division
337 West 44th Street
New York, NY 10036

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

The claim form must be completed clearly and accurately. Be sure to have the doctor, dentist, or other professional, who provided you with the service, complete the designated portion of the claim form. Submit all claims in English or with an English translation (claims not in English will not be processed and will be returned to you).

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TYPES OF CLAIMS AND TIME FOR THE PLAN TO RESPOND TO THOSE CLAIMS

The claims procedures for health benefits (including hospital, medical, dental, and prescription benefits) will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Post-Service Claim (as such terms are defined below). The claims procedures will also differ if your claim is for Loss of Time Benefits or Death or Accidental Death and Dismemberment Benefits. Read each section carefully to determine which procedure is applicable to your request for benefits. This information about the types of claims is provided as general guidance in accordance with the U.S. Department of Labor regulations.

PRE-SERVICE/PRE-CERTIFICATION AND URGENT CARE CLAIMS

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Please refer to the PPO Booklet (copy of which is attached to this SPD as Appendix A) and Section 2, 3, 4, 5 and 6 of this SPD for more information regarding when prior approval is required.

Please remember that, if you fail to pre-certify when you are required to do so, your Plan benefits may be reduced or eliminated, as set forth in SPD.

If you improperly file a Pre-Service Claim, the applicable organization responsible for making the claims determination will notify you of the proper procedures to be followed in filing a claim as soon as possible but not later than five (5) days after receipt of the claim. Unless the claim is re-filed properly, it will not constitute a claim. You will only receive notice of an improperly filed Pre-Service 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.

For properly filed Pre-Service Claims, you and/or your health care provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the organization responsible for making the claims determination, and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the applicable organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The applicable organization then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination. You have the right to appeal an adverse benefit determination with respect to your Pre-Service Claim. See "Review Process" and "Timing of Notice of Decision on Appeal" below.

Urgent Care/Pre-Certification Claims

An Urgent Care Claim is any claim for hospital, medical, dental or prescription care or treatment for which the application of the time periods for making Pre-Service Claim determinations:

- (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether or not your claim is an Urgent Care Claim, such claim shall be determined by the applicable organization applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

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If you improperly file an Urgent Care Claim, the organization responsible for reviewing the claim will notify you and/or the provider of the proper procedures to be followed in filing a claim as soon as possible but not later than 24 hours after receipt of the claim. Unless the claim is re-filed properly, it will not constitute a claim.

If you are requesting pre-certification of an Urgent Care Claim, the time deadlines are different than they are for Pre-Service Claims. The applicable organization will respond to you and/or your provider with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the applicable organization. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the organization responsible for making the decision will notify you and/or your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the organization receives the specified information or the end of the period given for you to provide this information, whichever is earlier. You have the right to appeal an adverse benefit determination with respect to your Urgent Care Claim. See the subsections entitled “Review Process” and “Timing of Notice of Decision on Appeal” below.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval for an on-going course of treatment (over a period of time or number of treatments) was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five (5) days that is reviewed at three (3) days to determine if the full five (5) days is appropriate). In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously-approved course of treatment prior to the end of the approved period of time or number of treatments (other than by plan amendment or termination) will be made by the applicable organization as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment beyond the previously-approved period of time or number of treatments will be acted upon by the organization responsible for making the determination within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If the request is not received at least 24 hours prior to the expiration of the treatment, it will be treated as an Urgent Care Claim and decided in accordance with the time frames applicable to Urgent Care (see above). A request to extend approved treatment that does not involve Urgent Care will be treated as a new benefit claim and will be decided according to Pre-Service or Post-Service Claim time frames, whichever applies. You have the right to appeal an adverse benefit determination with respect to your Concurrent Claim. See the subsections entitled “Review Process” and “Timing of Notice of Decision on Appeal” below.

Post-Service/Retrospective Claims

A Post-Service Claim is a claim (other than a Death Benefit, Accidental Death and Dismemberment Benefits, or Loss of Time Claim) that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained). For notification of a decision on a Post-Service Claim and the Appeal and Review process for such claims, see below.

For all Post-Service Claims, ordinarily, you will be notified of the decision on your claim within 30 days from receipt of the claim by the organization responsible for making the claims determination. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the organization responsible for making the claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

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If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The applicable organization then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Disability/Loss of Time Claims

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

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

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

Death Benefit and Accidental Death and Dismemberment Benefit Claims

A Death Benefit Claim is a claim for Death Benefits, and an Accidental Death and Dismemberment Benefit Claim is a claim for Accidental Death and Dismemberment Benefits.

The Fund Office will make a decision on these types of claims and notify you in writing within 90 days of receiving them. Under special circumstance, an extension of time, not exceeding 90 days, may be required. If such an extension is needed, you or your beneficiary will be notified in writing, before the initial 90 day period expires, of the special circumstances and the date when a decision will be made.

Pre-Certification Requirements

As indicated above, the Plan requires pre-certification for certain benefits. Please refer to the insurance booklets with Empire Blue Cross Blue Shield for a list of the specific benefits that are subject to the pre-certification requirements under the Plan. That said, effective as of September 1, 2013, the Plan removed the pre-certification requirements for the following benefits:

- Home Health Care (includes home infusion billed by HHC agency)
- Home Infusion Therapy (billed by a home infusion specialist)
- Hospice (inpatient and outpatient)
- Vision Therapy
- Cardiac Rehabilitation
- Air Ambulance – Emergency Only

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However, effective September 1, 2013, genetic testing will require a pre-certification. In addition, effective as of November 22, 2015, pre-certification will be required for the following medical diagnostic scans or tests:

- PET scans (Positron Emission Tomography)
- CAT scans (Computed Axial Tomography)
- Nuclear Stress Testing
- Echocardiogram

All other benefits available under the Plan that are not specifically referenced above and previously required a pre-certification prior to the above-referenced effective dates will continue to impose such a requirement after such dates. Please refer to the insurance booklets with Empire Blue Cross Blue Shield for a list of the specific benefits that are subject to the pre-certification requirements under the Plan.

WHEN, HOW, AND WHERE CLAIMS MUST BE FILED

Claims should be filed within the time frames, which are described below, or in the PPO Booklet (which is attached to this SPD as Appendix A. However, if it was not reasonably possible to file the claim within the time required, the failure to file claims within that time will not invalidate or reduce the claim.

If you receive benefits from an “In-Network” provider under the Plan, you generally do not have to submit a claim form. In this regard, when you visit a participating “In-Network” physician or facility, simply present, if necessary, your applicable identification card and make any Co-payment that may be required. In connection with these services, you may also be provided with an explanation of benefits (“EOB”) detailing such services, charges, amounts paid, and any Co-payment, Deductible and or Co-insurance due from you. Please review these EOB statements carefully for accuracy, as you are the best defense against fraudulent or inaccurate claims. For all other benefits, you may call the Fund Office at (212) 541-9880 or visit our website at www.local94.com.

Note: Request for treatment involving *Urgent Care* may be submitted by telephone to the organization that is responsible for administering the particular benefit you are requesting. (See section below entitled “Where to File Claims” for organization names and telephone numbers or check the back of your ID card.)

If you receive benefits from an Out-of-Network Provider and need to submit a claim, you should:

1. Obtain a claim form and complete the employee’s portion of the claim form;
2. Have your Physician complete the Attending Physician’s Statement section of the claim form;
3. Have the provider submit a HIPAA-compliant electronic claims submission; and/or
4. Attach any other itemized hospital bills or doctor’s statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Mail any further bills or statements for services covered by the Plan to the applicable organization as soon as you receive them.

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WHERE TO FILE CLAIMS

Your claim will be considered to have been filed as soon as it is received at the address below by the organization that is responsible for determining the initial determination of the claim.

Hospital Claims

For Post Service Claims, you are generally not required to file a claim form in order to be reimbursed for hospital benefits because most claims are submitted directly to Empire Blue Cross Blue Shield by the hospital. If you need to submit a claim, submit it to:

Empire Blue Cross Blue Shield Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
1-800-553-9603

For Pre-Service or Urgent Care Claims, you may call Empire Blue Cross Blue Shield at 1-800-553-9603

All Hospital Claims must be submitted within one (1) year of the date charges are incurred.

Medical Claims

You are generally not required to submit a claim for benefits you receive from In-Network PPO Covered Providers. You also need not submit a claim for benefits if you visit a PEMG location for a physical exam benefit or you visit any of the Plan's three eyeglass care networks for eyeglass benefits.

For Infertility Prescription claims, you must submit prescription claim to the Fund Office and the Fund will submit to Empire.

For Fund-Office Administered Benefits (except as provided below or in the previous paragraph), file these claims with the Fund Office at:

Health and Benefit Fund of the
I.U.O.E. Local Union 94-94A-94B, AFL-CIO
337 West 44th St.
New York, NY 10036

For PPO benefits that are provided Out-of-Network, file these claims with Empire Blue Cross Blue Shield. If you need to submit a claim, submit it to:

Empire Blue Cross Blue Shield Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
1-800-553-9603

All Medical Claims must be filed within one (1) year of the date charges are incurred.

Effective as of September 1, 2013, Empire Blue Cross Blue Shield will also perform medical and case management services for the Plan. If you have any questions or requests for medical management services, please call 1-800-553-9603.

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Dental Claims

Sele-Dent will also be administering **ALL** claims. All claims submissions including non-participating dental claims should be sent directly to:

Sele-Dent, Inc.
One Huntington Quadrangle
Suite 1-S03
Melville, NY 11747
1-800-520-3368

All Dental Claims must be filed within one (1) year of the date charges are incurred.

Prescription Benefits

You are generally not required to submit a claim for prescriptions filled at a pharmacy. However, if you need to submit a claim for a prescription it should be sent to:

Caremark, Inc.
P.O. Box 52196
Phoenix, AZ 85072-2196
1-888-769-9054

All Prescription Drug Claims must be filed within one (1) year of the date that the charges are incurred.

Loss of Time, Death and Accidental Death and Dismemberment Benefits

Submit claims for Loss of Time, Death and Accidental Death and Dismemberment Benefits to the Fund Office at:

Health and Benefit Fund of the
I.U.O.E. Local Union 94-94A-94B, AFL-CIO
337 West 44th St.
New York, NY 10036

You must complete the claim form in its entirety and attach the necessary documentation.

Death Benefit and Accidental Death and Dismemberment Benefit Claims must be filed within one (1) year of the date of death or dismemberment (as applicable). Loss of Time Benefits must be filed within one (1) year of the disability entitling you to benefits.

NOTICE OF DECISION ON CLAIM DETERMINATION

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

The specific reason(s) for the determination;

Reference to the specific Plan provision(s) on which the determination is based;

A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

A description of the appeal procedures and applicable time limits;

A statement of your right to bring a civil action under Section 502(a) of ERISA, following an adverse benefit determination on review;

For health benefit claims and disability claims, 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;

For health benefit claims and disability claims, 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 Plan to your claim, or a statement that it is available upon request at no charge; and

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For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification. In addition, for Urgent Care Claims (including Concurrent Care Claims processed under the special Urgent Care Claim 24-hour time period) and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

APPEALS PROCEDURES

Request For Review Of Denied Claim

If your claim is denied in whole or in part, if any adverse benefit determination is made with respect to the claim, or if you disagree with the decision made on a claim, you may ask for a review in accordance with the terms of this SPD and the terms of the applicable certificate of insurance booklet (PPO Booklet) with Fund's insurers, preferred provider organizations and/or pharmacy benefit managers (currently Empire Blue Cross Blue Shield, CVS/Caremark or Sele-Dent). Your request for review must be made in writing to the organization responsible for reviewing the claim within **180 days** after you receive notice of denial except for Accidental Death and Dismemberment Benefit and Death Benefit Claims which have a **60-day** time limit for filing an appeal.

Empire Blue Cross Blue Shield Claims

The appeals for Empire Blue Cross Blue Shield Claims can be made by calling (800) 553-9603 or contacting in writing:

Empire Blue Cross Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attn: Appeals Department

If your grievance or appeal concerns behavioral healthcare, call (800) 553-9603 or write to:

Empire Blue Cross Blue Shield
Grievances and Appeals
P.O. Box 2100
North Haven, CT 06743

Appeals involving Urgent Care Claims may also be made orally by calling Empire Blue Cross Blue Shield (800) 553-9603

Upon the completion of the appeals process, if you are still not satisfied by the decision made by Empire Blue Cross Blue Shield's you can appeal in writing to:

Health and Benefit Fund of the
I.U.O.E. Local Union 94-94A-94B, AFL-CIO
337 West 44th St.
New York, NY 10036
Attn: Board of Trustees

Caremark, Inc.

The appeals for Caremark Claims can be made by calling (888) 769-9054 or contacting in writing:

Caremark, Inc.
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

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Upon the completion of the appeals process, if you are still not satisfied by the decision made by Caremark, Inc. you can appeal in writing to:

Health and Benefit Fund of the
I.U.O.E. Local Union 94-94A-94B, AFL-CIO
337 West 44th St.
New York, NY 10036
Attn: Board of Trustees

Appeals for All Other Claims

All appeals for claims not administered by Empire Blue Cross Blue Shield or Caremark, Inc. should be made to the Fund Office at:

Health and Benefit Fund of the
I.U.O.E. Local Union 94-94A-94B, AFL-CIO
337 West 44th St.
New York, NY 10036
Attn: Board of Trustees

Review Process

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the applicable reviewing organization in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

For health benefit claims and disability claims, a different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. 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 documents and comments that may be submitted by you. In addition, if these claims are 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 will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

If your claim is denied in whole or in part, if any adverse benefit determination is made with respect to the claim, or if you disagree with the decision made on a claim, you may ask for a review in accordance with the terms of this SPD and the terms of the applicable certificate of insurance booklet (PPO Booklet) with Fund's insurers, preferred provider organizations and/or pharmacy benefit managers (currently Empire Blue Cross Blue Shield Blue Cross, CVS/Caremark or Sele-Dent).

If you do not request a review of a denied claim within 180 days, you will waive your right to a review of the denial. However, the applicable reviewer may not enforce this waiver if you can prove that you have a good reason for missing this deadline, provided you ask the applicable reviewer in writing to review the denial and you do so within one (1) year after the date shown on the notice of denial. You must file an appeal with the appropriate party and follow the process completely before you can bring an action in court. Failure to do so may prevent you from having a legal remedy.

Timing of Notice of Decision on Appeal

Subject to the terms of this SPD and the terms of the applicable certificate of insurance booklet (PPO Booklet) with Fund's insurers, preferred provider organizations and/or pharmacy benefit managers (currently Empire Blue Cross Blue Shield, CVS/Caremark or Sele-Dent), the following sets forth the relevant time periods for notice of decision on appeal.

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Pre-Service Claims (or Concurrent Claim that do not involve Urgent Care): You will be sent a notice of decision on review within 30 days of receipt of the appeal by the appropriate appeals reviewer.

Urgent Care Claims: You will be sent a notice of a decision on review within 72 hours of receipt of the appeal.

Post-Service Hospital: You will be sent a notice of decision on review within 60 days of receipt of the appeal.

Other Claims: Decisions on appeals involving Post-Service (other than Hospital Claims) and Death Benefit, Accidental Death and Dismemberment Benefit Claims, and Loss of Time Claims will be made at the next regularly scheduled meeting of the Board of Trustees (or its Appeals Subcommittee) following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

Notice of Decision on Review

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

The specific reason(s) for the determination;

Reference to the specific plan provision(s) on which the determination is based;

A statement of your right to bring a civil action under Section 502(a) of ERISA, following an adverse benefit determination on review;

For health benefit claims and disability claims, if an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and For health benefit claims and disability claims, 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 Plan to your claim, or a statement that it is available upon request at no charge.

All decisions on appeal will be final and binding on all parties, subject only to your right to bring a civil action under Section 502(a) of ERISA, after you have exercised the Plan's appeal procedures.

Limitation on When a Lawsuit May be Started

You may not start a lawsuit to obtain benefits until after you have completed the mandatory claim and appeal procedures and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The Trustees have established a three (3) year limitation period within which you may file a lawsuit for any claim for benefits offered under the Plan. Pursuant to this limitation, no lawsuit may be started more than three (3) years after the end of the year in which health services of any type (including, without limitation, medical, hospital, prescription drug and dental services) were provided, or, if the claims is for Loss of Time, Accidental Death and Dismemberment Benefits, or Death Benefits, more than three (3) years after the start of the disability, death or dismemberment, as applicable.

COORDINATION OF BENEFITS ("COB")

Because there are circumstances when you or your covered dependents may be entitled to medical benefits under this Plan as well as from some other source(s), the Fund has rules for the coordination of benefits between this Plan and such other sources of coverage. These rules shall apply to all benefits available under the Plan. Examples of your other sources of coverage include another group health care plan, Medicare or other government program, motor vehicle no-fault coverage, or Workers' Compensation. COB operates so that one of the plans or sources (called the Primary Plan) will pay its benefits first as if the other plan (called the Secondary Plan) did not exist. The Secondary Plan then may pay additional benefits subject to the respective maximum of the allowable charges for the covered services at issue.

In no event will the combined benefits of the Primary Plan and the Secondary Plan exceed one hundred percent (100%) of the medical or dental expenses incurred that are covered by such plans. Sometimes, the combined benefits that are paid will be less than the total expenses. Coordination of Benefits will ensure that you receive the maximum benefits allowed,

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while possibly reducing the cost of services to the Plan. You will not lose benefits under the Plan and may gain benefits if a Secondary Plan has better coverage in any area.

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying order of benefit determination rules in a specific sequence. The Plan's COB rules follow the order of benefit determination rules established by the National Association of Insurance Commissioners and which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first. Notwithstanding the COB rules discussed below, if you are eligible to participate in the Fund you must become a Member after you satisfy the service requirement for plan participation. You may not reject or waive coverage by the Fund for yourself or your Eligible Dependents. Accordingly, there is no "opt-out" provision that would otherwise allow employees and/or Members to reject coverage under the Fund. In this regard, if you are also covered under your spouse's group health plan, the Fund will consider such coverage under that plan as secondary coverage and the Fund's coverage as your primary coverage.

If the first rule below does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The COB rules are:

Rule 1: Non-Dependent/Dependent

The Plan that covers a person as an employee, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of Medicare rules, Medicare is:

**secondary to the plan covering the person as a dependent; and
primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);**

then the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the Calendar Year pays first; and the plan that covers the parent whose birthday falls later in the Calendar Year pays second, if:

The parents are married;

A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word "birthday" refers only to the month and day in a Calendar Year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first;
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

Section 7: Important Information

Rule 3: Active/Laid-Off or Retired Employee

Where a person is covered in one plan by reason of actual employment and in another plan by reason of laid-off or retired status, the plan that covers a person either as an active employee (that is, an employee who is neither laid off nor retired) or as that active employee's dependent, pays first; and the plan that covers that person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal (such as COBRA) or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person longer pays first; and the plan that covered the person for the shorter period of time pays second. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible under the second plan within 24 hours after the first plan ended. The start of a new plan does not mean or include a change:

**in the amount or scope of a plan's benefits;
in the entity that pays, provides or administers the plan; or
from one type of plan to another.**

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

When the Plan pays second, it will pay no more than 100% of "allowable expenses" less whatever payments were actually made by the plan (or plans) that paid first. "Allowable Expenses" means a Medically Necessary, reasonable, and customary health care service or expense that is covered in full or in part by any of the plans covering the person for whom the claim was made, except where a statute requires a different definition. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under the Plan.

ADMINISTRATION OF COORDINATION OF BENEFIT

To administer COB, the Fund reserves the right to:

Exchange information with other plans involved in paying claims;

Require that you or your health care provider furnish any necessary information;

Reimburse any plan that made payments the Fund should have made; or Recover any overpayment from the hospital, physician, dentist, other health care provider, other insurance company, you, or your dependents.

Section 7: Important Information

If the Fund should have paid benefits that were paid by any other plan, the Fund may pay the party that made the other payments in the amount the Board or its designee determines to be proper under these provisions. Any amounts so paid will be considered to be benefits under the Plan, and the Fund will be fully discharged from any liability it may have to the extent of such payment. Any person, who claims benefits under the Plan, must provide all the information requested by the Fund in order for the Fund to accurately apply the COB rules.

MEDICARE AND OTHER COVERAGE

Medicare: If you are actively employed and your or your spouse and/or your dependent child(ren) are covered by this Plan and by Medicare, then as long as you remain in current employment status, the Plan pays first and Medicare pays second. This means that after the Fund pays its benefits, you can submit a claim to Medicare for amounts not covered by the Fund. (A covered spouse will be treated the same way upon turning 65.)

If, while you are actively employed, any family member becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for a limited period of time. ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain his or her life. In general, Medicare imposes a three-month waiting period at the onset of end-stage renal disease before Medicare becomes effective. Medicare benefits begin three months after regular dialysis has started, or (if earlier) with the month the patient enters a hospital for a transplant. The three-month waiting period for dialysis patients does not apply to those entering self-dialysis programs. (Special provisions apply when a transplant fails or a new course of dialysis treatment is begun.) If there is a waiting period, the Plan continues to be the primary plan for the three-month waiting period. Whether or not there is a waiting period, the Plan will be the primary plan for the 30 month period after Medicare becomes effective. Medicare is the primary payor after the 30 month period.

If you are a Retiree and eligible for Medicare, Medicare will be your primary health benefit Plan. For Retirees, the Plan is not a primary or secondary payor of health claims. As a reminder, this Plan only provides Retirees with the Death Benefit and the Medicare Related Premium reimbursement benefit; provided that the Retiree meets the eligibility requirements applicable to Retirees as set forth in Section 1 of this SPD. Since the Plan does not provide or pay health claims for Retirees (or their spouses), the Plan does not coordinate benefits for Retirees with any other Plan including Medicare.

Medicaid: If a family member is covered by both the Plan and Medicaid, the Plan pays first and Medicaid pays second.

TRICARE: If a family member is covered by both the Plan and TRICARE, the Plan pays first and TRICARE pays second.

Workers' Compensation: The Plan does not provide benefits if the medical, dental or other expenses are covered by Workers' Compensation or occupational disease law.

If a Contributing Employer contests the application of Workers' Compensation law for the illness or injury for which expenses are incurred, the Plan will pay benefits, subject to the right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, you and/or your family member (as required by the Board) must execute a subrogation and reimbursement agreement acceptable to the Board (or its designee) in its sole and absolute discretion.

Motor Vehicle No-Fault Coverage Required by Law: If you or a family member is covered for hospital or medical benefits by both the Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and the Plan pays second.

Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other insurance provided by any other state or Federal law, the insurance provided by any other state or Federal law pays first and the Plan pays second.

Section 7: Important Information

OTHER INFORMATION ABOUT FUND BENEFITS

Subrogation – Fund’s Right to Restitution

If you or your Eligible Dependents are entitled to receive benefits from the Fund for injuries caused by a third party or as a result of any accident (for example, an auto accident), or if you or your Eligible Dependents receive an overpayment of benefits from the Fund, the Fund has the right in equity (or other means) to obtain full restitution of the benefits paid by the Plan from:

Any full or partial payment which your insurance carrier makes (or is obligated or liable to make) to you or your Eligible Dependents; and

You or your Eligible Dependents, if any full or partial payments are made to you or your Eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your, your dependent’s or a third party’s:

Automobile liability coverage;

Uninsured motorist coverage;

Underinsured motorist coverage;

Homeowner’s coverage; or

Other insurance coverage.

This means that, with respect to benefits which the Fund pays in connection with an injury or accident, the Fund has the right to full restitution from any payment received by you or your Eligible Dependents from any third party, whether or not the payment separately allocates an amount to the restitution of the expenses or types of expenses covered by the Fund or the benefits provided under the Fund. Any payment received by you, your legal counsel or your Eligible Dependents from a third party is subject to a constructive trust. Any third-party payment received by you or your Eligible Dependents must be used first to provide restitution to the Fund to the full extent of the benefits paid by or payable under the Fund. The balance of any third party payment must first be applied to reduce the amount of benefits which are paid by the Fund for benefits after the payment and second be retained by you or your Eligible Dependents. The Fund does not recognize the “Make Whole” Doctrine. However, in the event the Fund’s attorneys or administrator determine that the interests of all parties warrant a reduction in the amount of lien no language herein shall serve to restrict the right of the Fund to do so. Furthermore, no language herein shall be construed to confer the right of a reduction of lien to any Fund Member or beneficiary.

You and your Eligible Dependents are responsible for all expenses incurred to obtain payment from third parties, including attorneys’ fees, which amounts will not reduce the amount due to the Fund as restitution. The Fund expressly rejects the “Common Fund” Doctrine with respect to the payment of attorneys’ fees.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of another party, or if injuries resulted from your own acts, or the acts of your dependents, you should contact your attorney for advice and counsel. However, the Fund cannot and does not pay for your attorney fees. The Fund does not require you to seek any recovery whatsoever against another party or any other source, and if you do not receive any recovery, you are not obligated in any way to reimburse the Fund for any benefits that you applied for and accepted. However, the Fund is entitled to obtain restitution of any amounts owed to it either from third-party funds received by you or your Eligible Dependents, regardless of whether you or your Eligible Dependents have been fully indemnified for losses sustained at the hands of the third party. Accordingly, in the event that you do not pursue any and all third parties and responsible sources, the Fund is authorized to pursue, sue, compromise or settle (at the Board’s discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims and, furthermore, to fully cooperate with the Fund in the prosecution of such claims. In accordance with this authority, a Fund representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Fund’s equitable (or other) right to obtain restitution. To this end, by participating in the Fund, you and your Eligible Dependents acknowledge and agree to the terms of the Fund’s equitable (or other) rights to full restitution. You and your Eligible Dependents also agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Fund Administrator, including the signing of any documents or agreements necessary for the Fund to obtain full restitution.

Section 7: Important Information

By accepting benefits related to such illnesses or injuries, you and your Eligible Dependents agree:

that the Fund has established a lien on any recovery received by you (or your dependent, legal representative or agent); that the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the Member or dependent is made whole) and that the Fund's claim has first priority over all other claims and rights;

to notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to such illness or injury,

to notify the Fund Administrator as soon as possible and in writing that the Fund may have an equitable (or other) right to obtain restitution of any and all benefits paid by the Fund in connection with such injuries or illnesses;

to provide written notice to the Fund within ten (10) days after either you (or your dependent) or your attorney first attempt to recover such monies, or initiate a lawsuit, or enter into a settlement negotiation with another party or take and any other similar action;

to inform the Fund Administrator in advance of any settlement proposals advanced, or agreed to by a third party or a third party's insurer;

to provide the Fund Administrator all information requested by the Fund Administrator regarding an action against a third party, including an insurance carrier;

to provide written notice at least five (5) days in advance of the commencement of any litigation and any actions taken as part of such litigation including without limitation pretrial conferences or other important court dates and hearings (the Fund's representatives and counsel reserve the right to attend such pretrial conferences or other court proceedings);

to assign, upon the Fund's request, any right or cause of action to the Fund;

to fully cooperate with the Fund Administrator in all respects in the Plan's enforcement of its equitable (or other) rights to restitution and keep the Fund informed of any important developments in your action;

to not settle, without the prior written consent of the Fund Administrator, any claim that you or your Eligible Dependents may have against a third party, including an insurance carrier;

to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the costs of such collection, including but not limited to the Fund's attorney fees and costs; and to take all other action as may be necessary to protect the interests of the Fund.

In the event you or your Eligible Dependents do not comply with the requirements of this section, the Fund may deny benefits to you or your Eligible Dependents or take such other action as the Fund Administrator deems appropriate. In addition to all other remedies available under the law or equity, the Fund has the right to reduce future payments due to you or your Eligible Dependents (regardless of whether benefits have been assigned by a Member or covered dependent to the doctor, hospital or other provider) by the amount of benefits paid by the Fund. This right of recoupment shall not limit the equitable (or other) rights of the Fund to recover such moneys in any other manner.

Overpayment

If the Fund makes payment for benefits that are in excess of expenses actually incurred or in excess of allowable amounts, due to error or fraud or other reasons (including, without limitation, clerical error or the failure of a Member or a family member to notify the Fund Office regarding changes in family status), it reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action. Accordingly, if you (or your dependent or beneficiary) are overpaid for a claim, you (or your dependent or beneficiary) must return the overpayment within 60 days of the earlier of: the date that the Fund requests the return of such overpayment or the date that you discover the overpayment at issue. Amounts recovered may include interest, costs and attorneys' fees. If repayment is not made within this 60 day period, the Fund may deduct the overpayment amount from any future benefits from this Fund that you or your dependent or beneficiary would otherwise receive. If payment is made on your (or a dependent's) behalf to a hospital, doctor or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider and take whatever actions including without limitation deducting future benefit payments otherwise payable to the provider in order to recover such overpayment.

Section 7: Important Information

Plan Continuation

The Trustees hope to continue the Fund indefinitely. However, the Trustees reserve the right, in their sole and absolute discretion, to amend, modify or terminate the Fund and/or Plan at any time, for any reason, at any time and with respect to Members who are or may become covered and their dependents. Among other things, this shall empower the Plan Administrator to do the following:

change the eligibility rules;
diminish the amount of benefits;
increase or require deductibles or Co-insurance;
eliminate particular types of benefits;
substitute certain benefits for others; and
if deemed necessary by the Plan Administrator, require contributions or increase contributions from Members and beneficiaries as a condition of eligibility.

If the Plan is amended or terminated, in whole or in part, your right to participate in the Plan, as well as the type and amount of benefits provided under the Plan, may be changed or eliminated. If the Plan is terminated or otherwise amended, it will not affect your right to receive reimbursement for eligible expenses that you have incurred prior to the date of termination or amendment.

In the event that the obligations of the Contributing Employers to make contributions to the Fund cease or the Fund otherwise terminates, after payment of all expenses, the Trustees shall determine the distribution of the assets but only for the benefit of the Members and for the purposes set forth in the Plan (or the agreement and declaration of trust establishing the Fund), or as otherwise permitted by federal law. Notwithstanding the above, under no circumstances will any person obtain a vested or nonforfeitable right to receive, directly or indirectly, any assets of the Fund.

No Liability for Practice of Medicine

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

How Benefits May Be Reduced, Delayed or Lost

Throughout this SPD, we try to bring to your attention those circumstances that might lead to a loss of your eligibility to participate in and/or receive benefits under the Plan, and to describe any limitations, exclusions, or restrictions applicable to specific benefits.

We urge you to familiarize yourself with this information, especially as it relates to the requirements that must be met in order to maintain your eligibility to participate in the Plan and to receive benefits. Most of these circumstances are spelled out in this booklet, but benefit payments also may be affected if you, your beneficiary or your provider of services, as applicable, do not:
file a claim for benefits properly or on time,
furnish the information required to complete or verify a claim, or
have a current address on file with the Fund Office.

Remember: You must work the required number of hours in order to maintain your eligibility. (See the Eligibility section for applicable rules.) If at any time you are uncertain about how a specific circumstance might affect your eligibility or health benefit coverage, please contact the Fund Office and, if possible, try to do so before the circumstance arises. You should also be aware that Plan benefits are not payable for enrolled dependents who become ineligible due to age, marriage, or divorce, unless they elect and pay for COBRA benefits, (see the subsections entitled “When Coverage Ends” and “COBRA Continuation Coverage” as set forth in Section 1 herein).

If the Plan mistakenly pays more than you are eligible for, or pays benefits that were not authorized by the Plan, the Fund may seek any permissible remedy allowed by law to recover benefits paid in error (See the subsections entitled “Overpayments” and “Subrogation” as set forth in Section 7 herein).

Section 7: Important Information

Assignment of Plan Benefits

You cannot assign or transfer benefits to anyone other than a health service provider (which you do by completing a claim form, which the provider of **care** will submit to the Plan, or by completing a form the Fund will provide for this purpose). When the provider is not participating, ALL payments are generally made to the Member. You cannot pledge benefits owed to you for the purpose of obtaining a loan.

Benefits or payments under the Plan are not otherwise assignable or transferable, except as the law requires. Benefits are not subject to any creditor's claim or to legal process by any creditor of any covered individual, except under a QMCSO. For more information on QMCSO, please refer to the Subsection entitled "Qualified Medical Support Order" as set forth in Section 1 herein.

Late Payments

Interest will not be paid on benefits that are paid later than provided for in the Plan, regardless of the reason that the payment was delayed.

Plan Administration

The Plan is what the law calls a "health and welfare" benefits program. Benefits are provided from the Fund's assets. Those assets are accumulated under the provisions of the Agreement and Declaration of Trust establishing the Fund ("Trust Agreement") and are held in a Trust Fund for the purpose of providing benefits to covered Members and dependents and defraying reasonable administrative costs.

The Plan is administered by the Board, as the Plan Administrator. The Board governs this Plan in accordance with the Trust Agreement. Accordingly, please note that no individual other than the Board and its duly authorized designee(s), has any authority to interpret the Plan documents, including this SPD or the official Plan documents, or to make any promises to you about the Plan, or your benefits under the Plan, or to change the provisions of the Plan.

The Board and its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this SPD, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Fund. Without limiting the generality of the foregoing, the Board and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;

Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Plan;

Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this SPD, the Agreement and Declaration of Trust or other Plan documents;

Process and approve or deny benefit claims and rule on any benefit exclusions; and

Determine the standard of proof required in any case.

All determinations and interpretations made by the Board and/or its duly authorized designee(s) shall be final and binding upon all Members, beneficiaries and any other individuals claiming benefits from the Fund. The Board may delegate any other such duties or powers as it deems necessary to carry out the administration of the Plan. In this regard, the Board has delegated certain administrative and operational functions to the Fund Administrator and his/her staff, who can answer most of your day-to-day questions. If you wish to contact the Board, please write to:

Board of Trustees
Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036

Section 7: Important Information

Privacy of Protected Health Information

HIPAA is a federal law that imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information the Fund maintains about you, and knowing how your health information may be used. In April of 2003, the Board adopted certain HIPAA privacy and security language that required the Board, in its role as Plan Sponsor for the Fund, to keep your health information private and secure. A complete description of how the Fund uses your health information and your other rights under HIPAA's privacy rules is available in the Fund's "Notice of Privacy Practices" ("Privacy Notice") which is distributed to all named Members. A copy of the Fund's Privacy Notice is attached as Appendix "D." In general, HIPAA's privacy laws prohibit the Fund under most circumstances from providing your "protected health information" to anyone but you, unless you previously completed, signed and filed with the Fund an "Authorization for Release of Protected Health Information" ("Authorization"). Protected health information is information (including demographic information) which is created or received by the Fund, relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care, and which could reasonably be used to identify you. For example, husbands are not able to inquire on behalf of their wives with respect to the wives' medical bills, and vice-versa, unless the Fund Office receives an Authorization. Under most circumstances parents may inquire as to their minor (under the age of 18) children's bills, but children, who are 18 or over, need to complete an Authorization form. Anyone may request an additional copy, free of charge, of this Privacy Notice or Authorization form by calling the Fund Office at (212) 541-9880 or writing to the Fund Administrator at:

Health and Benefit Trust Fund of the
I.U.O.E. Local 94-94A-94B, AFL-CIO
Commercial Division
337 West 44th Street
New York, NY 10036

Genetic Information Non-Discrimination Act ("GINA")

Effective for plan years beginning on or after May 21, 2009, GINA prohibits discrimination by group health plans such as the Plan against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Plan is also prohibited from setting premium and contribution rates for the employer group on the basis of genetic information of an individual enrolled in the plan.

GINA requires the HIPAA Privacy regulations to be amended, effective May 21, 2009, to treat genetic information as protected health information. GINA prohibits the use of genetic information for underwriting purposes and makes the definitions of genetic information and underwriting consistent with GINA.

Women's Health and Cancer Rights Act of 1998

Because the Fund provides medical and surgical benefits in connection with a mastectomy, the Fund also provides benefits for reconstructive surgery. In particular, the Fund will provide, to a Member or beneficiary who is receiving (or presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

- all stage of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- prosthesis and physical complications associative with all stages of mastectomy, including lymphedemas.
- To the extent permitted by applicable law, this coverage will be subject to annual Deductibles, plan benefit maximums, Co-insurance and Co-payment provisions that may apply under the Fund. You should review carefully the provisions of the Fund regarding any such restrictions that may apply. Please remember that, as with all benefits, the Board reserves the right to amend, modify and/or terminate benefits at any time in accordance with the official plan documents and applicable law.

Section 7: Important Information

Pre-existing Conditions

A pre-existing condition is a condition that was present before the effective date of coverage under the plan regardless of whether you or your dependent received or were recommended any diagnosis, medical advice, care or treatment, or taken any prescribed drug. The Plan does not impose any pre-existing condition rules for the benefits provided herein including without limitation benefits provided to children under the age of 19.

Newborn's and Mother's Health Protection Act

Solely to the extent required by the Newborns' and Mothers' Health Protection Act (hereinafter "NMHPA"), the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA. Accordingly, with regard to these medical services, a Covered Provider is not required to obtain authorization from the Plan or the issuer for prescribing a length of stay for childbirth less than 48 hours for a normal delivery (or 96 hours for a cesarean section). Please check the PPO Booklet (copy of which is attached to this SPD as Appendix A) to see if a longer length of stay rule applies.

Mental Health Parity Act

This federal law, in general, requires that health insurance coverage of mental illnesses and disorders be treated the same as for physical illnesses and disorders. It equates lifetime limits and annual limits for mental health benefits with lifetime limits and annual limits for medical and surgical benefits. Stated differently, certain health plans offering mental health benefits are no longer allowed to set annual or lifetime dollar limits on mental health benefits that are lower than dollar limits for medical and surgical benefits. However, medical plans are allowed to specify inpatient day limits, and limitations on outpatient treatments. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations for mental health and substance use disorder benefits are no more restrictive than the requirements and limitations applied to medical or surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996. Notwithstanding anything contained in the Plan or otherwise, the Plan will comply in accordance with, and subject to the requirements of MHPAEA. To this end, effective January 1, 2013, the Plan has applied the same standards for deductibles, copays, coinsurance and out-of-pocket expense maximums for mental health and substance use disorder benefits as it applies to medical and surgical benefits, in accordance with, and subject to the requirements of MHPAEA. Accordingly, please refer to the PPO Booklet (copy of which is attached to this SPD as Appendix A) and certificate of coverage for any limits that may apply to your coverage election.

Nondiscrimination and Accessibility Requirements

The Health and Benefits Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO ("Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund provides free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters;
- written information in other formats (large print, audio, accessible electronic formats, other formats); and
- provides free language services to people whose primary language is not English, such as:
 - qualified interpreters;
 - information written in other languages.

If you need these services, contact Kathryn Fisler, Fund Administrator.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Fund Administrator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail at:

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

or by phone at: (800) 368-1019 or (800) 537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

ATTENTION: FREE LANGUAGE ASSISTANCE	
<i>This chart displays, in various languages, the phone numbers to call for free language assistance services for individuals with limited English proficiency.</i>	
<i>Spanish</i>	<i>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office for all other services 212-541-9880.</i>
<i>Chinese</i>	<i>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office for all other services 212-541-9880.</i>
<i>Russian</i>	<i>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>French Creole</i>	<i>ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Korean</i>	<i>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services 번으로 전화해 주십시오.</i>
<i>Italian</i>	<i>ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Yiddish</i>	<i>איפֿמערקזאָם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופ. Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Bengali</i>	<i>লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ – Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Polish</i>	<i>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Arabic</i>	<i>ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- (رقم هاتف الصم والبكم: Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>French</i>	<i>ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services. .</i>
<i>Urdu</i>	<i>خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Tagalog</i>	<i>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Greek</i>	<i>ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>
<i>Albanian</i>	<i>KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.</i>

Section 7: Important Information

Lifetime and/or Annual Dollar Maximum Limits on Essential Health Benefits

Consistent with the Health Care Reform law, the annual dollar limits set forth in the SPD will not apply to “essential health benefits” as defined under the Affordable Care Act. Generally speaking, the law defines “essential health benefits” to include, at a minimum, items and services covered within certain categories including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, chronic disease management services, and pediatric services, including oral and vision care. The determination as to whether a benefit constitutes an “essential health benefit” will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made. Essential health benefits will be paid at the reasonable and customary rates as determined by the Trustees as of the date on which the determination is made and in accordance with the terms set forth in the SPD. Generally speaking, reasonable and customary rates will typically track the Plan’s fee schedule for the corresponding in-network services/devices.

Facility of Payment

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits through the Plan is appointed by a court of competent jurisdiction, payments may be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Plan Administrator. To the extent permitted by law, any such payment so made will discharge entirely any obligation of the Fund.

Not a Contract of Employment

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

What Else Do You Need to Know About the Plan?

The following information concerning your Plan is provided in accordance with governmental regulations and ruling of the Internal Revenue Service and the Department of Labor, and current tax law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law will take precedent over state law.

You should also refer to the Administrative Information that follows the section on your rights under ERISA.

The Plan is a welfare benefit plan primarily providing group health benefits. The Plan is maintained and administered by a joint Board of Trustees that includes four (4) Union Trustees and four (4) Employer Trustees with equal voting strength. The Board of Trustees serves as the Plan Administrator and is the designated agent for service of legal process.

The Board of Trustees believes that the Plan is a “grandfathered plan” as such term is defined under the Health Care Reform law. As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the Health Care Reform law was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of the Health Care Reform law that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., copayments, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 331-1800. You may also contact the Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

The Board of Trustees has the primary responsibility for decisions regarding eligibility rules, types of benefits, administrative policies, and interpretation of Plan provisions.

Section 7: Important Information

The Board has delegated many of the day-to-day administrative functions to the Fund Administrator and the staff of the Fund Office. The Fund Administrator and Fund Office staff are employees of the Fund. They maintain eligibility records, account for employer contributions, process self-funded claims, make self-funded benefit payments, answer benefits questions from Members and beneficiaries, file required government reports, and handle other necessary administrative functions under the direction of the Trustees.

If you wish to contact the Board of Trustees, write to:

Board of Trustees
Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036

Keeping Your Fund Records Up to Date: Your Responsibilities

It is your responsibility to be aware of the rules of the Fund. You should contact the Fund Office if you have any questions concerning the Fund.

It is also your responsibility to notify the Fund Office immediately if any of the following occurs:

Change of address,
Marriage, divorce, or legal separation,
Birth or adoption of a child,
You become financially responsible for a step-child,
You or your spouse has other coverage or health insurance,
You or your dependents are involved in an accident for which you may file benefit claims,
You or your spouse becomes eligible for Medicare,
You retire,
You have not completed an enrollment card or wish to change your beneficiary for death benefits, or
If your unmarried dependent child is or becomes incapable of sustaining employment by reason of mental retardation or physical handicap prior to his or her 19th birthday.
If an eligible adult dependent child obtains health insurance coverage through an employer,
In addition, your spouse or other family member must notify the Fund Office in the event of your death.

Your Rights Under the Employee Retirement Income Security Act (ERISA)

As a Member in the Plan, you are entitled to certain rights and protections under ERISA. In general, ERISA provides that all Plan Members shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, locations and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series), filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA").

Obtain, upon written request to the Plan Administrator, copies of the documents governing the operations of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights. If you change medical plans and wish to have any pre-existing conditions covered by the new plan, you will need a Certificate of Creditable Coverage. You can get a Certificate of Creditable Coverage free of charge from the Plan when you lose coverage, when you become entitled to elect COBRA Continuation Coverage ceases, if you request it before losing such coverage, or if you request it up to 24 months after losing such coverage. Without evidence of creditable coverage, you

Section 7: Important Information

may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in the new plan.

In addition to creating rights for Plan Members, ERISA imposes duties upon the people who are responsible for the administration and operation of your benefit Plan. The people who administer your Plan are called “fiduciaries.” Fiduciaries of the Plan have a duty to administer the Plans prudently and in the interest of you and other Plan Members and beneficiaries.

No one—including your Contributing Employer, your union or any other person—may fire you or in any way discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, in accordance with the Plan’s appeal procedures. You also have the right to have the Plan review and reconsider your claim.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court after you have exhausted the Plan’s claims and appeal procedures. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. However, you may not file a lawsuit until you have followed the Plan’s claims and appeal procedures described in Section 7 herein. The court will decide who should pay court costs and legal fees. If the court decides in your favor, it may order the person you have sued to pay these costs and fees. If the court decides against you, it may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Board (your Plan Administrator):

Board of Trustees
Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036

You also may call the Fund Office at (212) 541-9880.

If you have any questions about this statement or about your rights under ERISA, you should contact the Trustees or the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory, or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the EBSA or by visiting the Department of Labor’s website: <http://www.dol.gov>.

Section 7: Important Information

ADMINISTRATIVE INFORMATION

The Fund Office should be able to handle most of your questions about the Plan. However, if it ever becomes necessary to contact the U.S. Department of Labor, you will need the following identifying information.

Official Name of the Plan

Health and Benefit Trust Fund of the International Union of Operating Engineers, Local 94-94A-94B, AFL-CIO.

Plan Sponsor and Administrator

Board of Trustees
Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036
(212) 541-9880

As stated earlier, the Plan is maintained and administered by a joint Board of Trustees that includes four (4) Union Trustees and four (4) Employer Trustees with equal voting strength.

Employer Identification Number (EIN) - 13-6674743

Plan Number - 501

Type of Plan - The Plan is a welfare benefit plan primarily providing group health benefits.

Medical & Hospitalization benefits are administered by Empire Blue Cross Blue Shield and/or the Fund Office. Empire Blue Cross Blue Shield's address is:

Empire Blue Cross Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
1-800-553-9603

The Fund Office's address is:

Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036
(212) 541-9880

Prescription Drug benefits are self-funded and administered by CVS/ Caremark. Their address is:

CVS /Caremark
P.O. Box 2110
Pittsburgh, PA 15230-2110
(888) 769-9054

Dental benefits are administered by Sele-Dent. Their address is:

Sele-Dent, Inc.
One Huntington Quadrangle
Suite 1-S03
Melville, NY 11747
1-800-520-3368

Section 7: Important Information

Plan Contributions

All contributions to the Fund are made by Contributing Employers in accordance with their written agreement with Local 94, 94A, 94B. The collective bargaining agreement requires contributions to the Fund at fixed rates per hours worked. Upon written request, the Fund Office will provide Members and beneficiaries with information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

Funding Method

The Fund maintains a trust that includes all contributions to the Plan (and any other plan maintained by the Fund) and investment income, from which all benefits and administrative expenses are paid.

Agent for Service of Legal Process

Board of Trustees
Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036

Legal process may be served on the Plan Administrator or any individual Trustee.

Collective Bargaining Agreements

This Plan is maintained according to the terms of several collective bargaining agreements. A copy of such agreements may be obtained upon written request to the Fund Office and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the Contributing Employers and employee organizations sponsoring the Plan may be obtained upon written request to the Fund Office and is available for examination by Members and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Plan Year

January 1 - December 31

Section 8: Sick Fund

SECTION 8: SICK FUND

Eligibility and Contributions for Sick Leave Benefits

In accordance with the applicable terms of the collective bargaining agreement between NYC School Support Services, Inc. and the Union, effective as of August 12, 2016, contributing employers pay for the full cost of the sick leave benefits available under the Fund. The amount your employer contributes for sick leave benefits on your behalf is set forth under the CBA. As an example, for the 2017 plan year, the employer contribution rate for a firemen/helper is \$1.15 per hour paid in covered employment and for an engineer the employer contribution rate is \$1.56 per hour paid in covered employment. You are not required (nor are you allowed) to make contributions to the Fund.

However, in order to be eligible to receive contributions for sick leave benefits under the CBA, you must work at least one hundred (100) hours or more in covered employment during any calendar month that is reported for this purpose. As such, no contributions shall be required or be made for any participant who worked less than 100 hours in covered employment during a calendar month.

An individual account will be set up in your name and will be credited with all employer contributions for sick leave benefits that have been paid on your behalf under the Fund.

Sick Leave Benefits

To the extent that sick leave contributions have been credited and you have a sufficient balance in your individual account under the Fund, you may apply to receive eight (8) hours pay at your current rate of pay for each full day that you are absent from work due to illness.

If you have unused sick pay credit at the end of a calendar year, you may carry forward your credit to the following calendar year. As such, sick pay benefits will not be forfeited at the end of any calendar year.

If you die with any accumulated unpaid sick leave benefits, the Fund will pay the outstanding balance in your individual account to your designated beneficiary (or, if none, to your estate), subject to certain limitations imposed by applicable law and upon receipt of a completed application for such benefits. If you leave the industry permanently, you will be paid any accumulated unpaid sick leave in your individual account upon application to the Fund, subject to certain limitations imposed by applicable law and upon receipt of a completed application for such benefits.

Applying for Sick Leave

In order to obtain sick leave benefits, you must file an application (on the form provided by the Fund Office) and present any required documentary evidence requested by the Fund Office. You may obtain copies of the application form for sick leave benefits by contacting the Fund Office or from the Fund's website: www.local94.com. In order to be considered for approval, all applications must be fully completed and signed by the participant and his or her direct supervisor, and the original executed application must be hand-delivered or mailed to the Fund Office. Applications that are not completed correctly will not be approved. Upon approval, the Fund will issue a check for the eligible sick leave benefits. Checks are generally issued Monday through Friday between 8:30am - 11:30am. You may either pick up your sick leave benefit check in person by presenting your driver's license or passport to the Fund Office, or have it mailed to you at your address on record.

As a reminder, a participant does not have the right to simply withdraw an amount from their individual account for sick leave benefits in excess of wage replacement for the period of time the participant is absent from work due to sickness.

Please note that the Fund will withhold your share of FICA taxes on any sick leave benefits you receive and remit such taxes to the Internal Revenue Service. At the beginning of each Calendar Year, a W-2 form will be issued to each member who collected sick leave pay in the previous calendar year.

Section 8: Sick Fund

Naming your Beneficiary

Your beneficiary for the Health and Benefit Fund Accidental Death and Dismemberment and Death Benefit will be the same as your Beneficiary for the Sick Fund.

Contact Information

If you have any questions or concerns regarding your sick leave benefits or balance in your individual account under the Fund, please call Sarah Cole at (212) 331-1802 or email at sarahcole@local94.com.

Final Word

A FINAL WORD

This SPD constitutes the Plan's written plan document and supersedes all prior SPDs, plan rules and other noticed issues prior to the effective date of this SPD. This SPD applies to the services rendered on or after the effective date of its issuance, January 1, 2018. For services rendered prior to that date, please refer to the Fund's prior SPD, notices and documents for the applicable period.

However, additional information about the Plan is available in the other official Plan documents, including the Trust Agreement or the Plan's respective contracts and certificate of insurance booklets with its insurers, preferred provider organizations and pharmacy benefit managers (currently Empire Blue Cross Blue Shield, CVS/Caremark or Sele-Dent), or applicable collective bargaining or other written agreements between your Contributing Employer and the Union. All statements made in this SPD booklet are subject to the provisions and terms of those other official plan documents. If there is any conflict between these documents and the SPD, these official plan documents will control instead of the SPD.

The Trustees have the exclusive right and authority to administer and interpret the Plan, Trust Agreement and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan or the Trust and the investment of Plan assets.

Please call the Fund Office at (212) 541-9880 any time you have questions about your benefits under the Plan.

The Fund Office's regular office hours are Monday through Friday, 8:00 a.m. to 4:00 p.m.

PPO BOOKLET
Empire Blue Cross Blue Shield's
Preferred Provider Organization (PPO)
Certificate of Insurance Booklet for
Hospital and Medical Benefits
for the
Health & Benefit Trust Fund of the I.U.O.E.
Local 94-94A-94B AFL-CIO

School Division

Group 376334-4 (Actives)

Effective as of January 1, 2018

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association,
an Association of independent Blue Cross and Blue Shield Plans.

Blue Cross, Blue Shield, the Cross and Shield symbols and BlueCard are registered marks of the
Blue Cross and Blue Shield Association.

AT&T Direct is a registered mark of AT&T. 360 Health is a registered service mark.

Welcome

Welcome to Empire's Preferred Provider Organization ("PPO"), which is a network of physicians and other health care Providers who agree to offer medical or hospitalization services and/or supplies according to an established fee schedule or pre-negotiated rate. With Empire BlueCross BlueShield ("Blue Cross" or "Empire"), you have access to great coverage, flexibility and all the advantages of quality care. The specific health and medical benefits that are available under the PPO are established pursuant to a written agreement between Empire and the Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO (referred to as either the "Plan" or the "Fund"). Accordingly, this benefits booklet explains the specific health and medical PPO benefits for members who are actively employed and any eligible individuals who have elected COBRA Continuation Coverage; as well as their eligible dependents. This booklet also explains exactly how you access such healthcare services and how we can help you make the most of your plan. Accordingly, this booklet is designed to provide you with an overview about the medical coverage that is available under Empire's PPO and how to file claims, if necessary, to receive such coverage. Please refer to the Fund's Summary Plan Description ("SPD") for all other information regarding your rights and responsibilities under the Plan. For instance, the SPD contains the Plan's rules including without limitation those that govern your eligibility to participate in the Plan as an active member, when you (or your dependent) loses coverage under the Plan, your (or your dependent's) rights to continue coverage under COBRA, coordinating the payment of benefits under the Plan or the PPO with other sources of coverage, how to file appeals with regard to the denial of benefits, etc. To the extent that there is a conflict between this booklet and the SPD regarding such rules, the Fund's SPD will control.

If you have questions or require information regarding the PPO Network including the most current list of participating Providers, you may call Empire Blue Cross Blue Shield's Member Services at (800) 553-9603 or logging onto its website at www.empireblue.com. Also, you can obtain information by visiting the Local 94 website at: <http://www.local94.com> or by calling (212) 541-9880.

Retirees (as defined in the Summary Plan Description for the Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL CIO Active and Retiree Members in the School Division effective January 1, 2018) are not eligible for any benefits set forth or discussed in this Appendix A PPO Booklet. If you have any questions you can visit the Local 94 website at: <http://www.local94.com> or by calling (212) 541-9880.

Grandfathered Health Plan

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

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Empire at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

STOP FRAUD

Empire BlueCross BlueShield welcomes your help in preventing health insurance fraud. Fraud costs Empire and its customers millions of dollars each year. If you are aware of any illegal activity involving Empire BlueCross BlueShield, please make a confidential call to this phone number during normal business hours:

INTEGRITY HOTLINE: 1-800-I-C-FRAUD (423-7283)

Your PPO – A Smart Way To Get Healthcare

As indicated above, the PPO offers a network of healthcare Providers available to you through Empire. If you think about your town, it includes doctors, hospitals, laboratories and other medical facilities that provide healthcare services – that’s what we mean by healthcare “Providers.” Some healthcare Providers contract with health plans like Empire BlueCross BlueShield to provide services to members as part of the plan’s “network.” With Empire’s PPO, when you need healthcare services, you have a choice. Depending on the healthcare service you need, you are free to get care from Providers participating in your PPO network or you can choose to use outside Providers.

WHAT’S THE EMPIRE PPO ADVANTAGE?

When you use Empire’s PPO network to access healthcare, you get:

- A comprehensive Web site, www.empireblue.com, for fast, personalized, secure information
- Among the largest network of doctors and hospitals in New York State
- Providers that are continuously reviewed for Empire’s high standards of quality
- The ability to choose In-Network or Out-of-Network care for most Covered Services
- Minimal out-of-pocket costs for preventive care, behavioral health care, and a wide variety of hospital and medical services when you stay In-Network
- Easy to use – no claim forms to file when you stay In-Network
- Coverage for you and your family when traveling or living outside of Empire’s service area

HOW TO USE THIS GUIDE

This Guide gives you an overview of the features and benefits of your plan. Use it as a reference to find out what’s covered, what your costs are, and how to get healthcare services any time you or a covered family member need them.*

You’ll find the information you need divided into sections. Here’s a quick reference:

<i>IF YOU ARE LOOKING FOR ...</i>	<i>YOU’LL FIND IT IN</i>	<i>ON PAGE</i>
• HOW THE PLAN WORKS	USING YOUR PPO	A-8
• WHAT’S COVERED	COVERAGE	A-21
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	A-37
• HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, OUR CONFIDENTIALITY POLICY, AND YOUR LEGAL RIGHTS UNDER HIPAA	DETAILS AND DEFINITIONS	A-44

* This booklet describes only the highlights of your medical coverage. It does not attempt to cover all the details. Additional details are provided in the official plan documents (such as the Fund’s SPD) and insurance and/or service contracts between Blue Cross and the Fund, which legally govern the plan. In the event of any discrepancy between this booklet and the official plan documents, the official plan documents will govern.

Manage Your Healthcare Online

REGISTER NOW TO DO IT ON THE WEB

Go to www.empireblue.com where you can securely manage your health plan 24 hours a day, 7 days a week. Here's what you can do:

- Check status of claims
- Search for doctors and specialists
- Update your member profile
- Get health information and tools with My Health powered by WebMD
- Print plan documents
- Receive information through your personal "Message Center"

Plus much more ...

HERE'S WHAT YOU'LL NEED TO DO

All members of your family 18 or older must register separately:

- Go to www.empireblue.com
- Click on the Member tab and choose "Register"
- Follow the simple registration instructions

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

Click on MY HEALTH from your secure homepage after you register to receive the following features:

- Take the *Health IQ* test and compare your score to others in your age group
- Find out how to improve your score – *and your health* – online
- Find out how to take action against chronic and serious illnesses
- Get health information for you and your family.

YOUR PRIVACY IS PROTECTED

Your information is protected by one of the most advanced security methods available.

Register today to experience hassle-free service!
www.empireblue.com

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Introduction

Getting Answers Your Way

Empire gives you more choices for contacting us with your customer service questions. Use the Internet, phone or mail to get the information you need, when you need it.

ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit www.empireblue.com. At Empire, we understand that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially. Nervous about using your PC for important healthcare questions or transactions? We've addressed that too! Just "click to talk" to a representative or send us an e-mail.

BY TELEPHONE

WHAT	WHY	WHERE
<p>MEMBER SERVICES</p> <p>BEHAVIORAL HEALTHCARE MANAGEMENT</p>	<p>For questions about your benefits, claims or membership</p> <p>To locate a participating behavioral healthcare Provider in your area</p> <p>Precertification of mental health and alcohol/substance abuse care</p>	<p>1-800-553-9603 TDD for hearing impaired: 1-800-241-6894. 8:30 a.m. to 5:00 p.m. Monday – Friday</p>
<p>BLUECARD® PPO PROGRAM</p>	<p>Get network benefits while you are away from home</p> <p>Locate a PPO Provider outside Empire's network service area</p>	<p>1-800-810-BLUE (2583) www.bcbs.com 24 hours a day, 7 days a week</p>
<p>ATT SERVICIOS PARA IDIOMAS EXTRANJEROS</p>	<p>Si usted no habla inglés</p>	<p>1-800-553-9603 Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes</p>
<p>MEDICAL MANAGEMENT PROGRAM</p>	<p>Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies</p>	<p>1-800-553-9603 8:30 a.m. to 5:00 p.m. Monday – Friday</p>
<p>24/7 NURSE HOTLINE AND AUDIO HEALTH LIBRARY</p>	<p>Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes</p>	<p>1-877-TALK-2RN (825-5276) 24 hours a day/7 days a week</p>
<p>FRAUD HOTLINE</p>	<p>Help prevent health insurance fraud</p>	<p>1-800-IC-FRAUD (423-7283) 9:00 a.m. to 5:00 p.m. Monday-Friday</p>

IN WRITING

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

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans

Your Identification Card

Empire has created an identification card to make accessing your healthcare as easy as possible. The Empire BlueCross BlueShield I.D. card is a single card that you can use for all your Empire health insurance services, as it shows each of the plans or programs you're enrolled in. Always carry it and show it each time you receive healthcare services. Every covered member of your family will get their own card. The information on your card includes your name, identification number, and various Co-payment amounts.

The diagram shows an Empire BlueCross BlueShield I.D. card with the following fields and callouts:

- Cardholder name:** JOHN Q. PUBLIC
- Member ID number:** Identification Number XXX1234567800
- Group number:** Group: 246680 749
- A number used by Empire to determine cardholder relationship to the contract holder:** Relationship Code: 01
- Description of plan design:** Health Plan: PPO
- Additional coverage:** Dental: Yes, Vision: Yes, BS Plan: 803 BC Plan 303
- Rx Co-pay:** \$10/\$25/\$50
- Rx Deductible:** \$100
- RX Bin#/PCN:** 000000/00000
- Rx Group:** Empire
- Office Visit Co-pay:** \$30
- ER Co-pay:** \$75
- In-Network Deductible:** \$1,000
- In-Network Coinsurance:** 20%
- Icons:** PPO, Rx

Callouts on the right side of the card explain the following:

- Pharmacy co-payments if a pharmacy program was chosen
- The deductible you must pay each calendar year before your Rx plan pays benefits
- Code used by pharmacies to identify Empire
- Office visit co-payment
- Emergency room co-payment
- The deductible you must pay each calendar year before your plan pays benefits
- After you have met your deductible for covered expenses other than prescription drugs, you are responsible for this percentage of the provider fee allowed by Empire

To make it easier for you to use your new card, following are answers to some frequently asked questions:

Q: *Why is Empire issuing this kind of I.D. card?*

A: Empire's card has all the information Providers need to know to serve our members' healthcare needs. Our design eliminates the need for you to carry multiple cards.

Q: *What do the icons on the card mean?*

A: The icons are illustrations of the plan(s) that you've enrolled in. The first icon shows that you're enrolled in the PPO. The other icons show which additional plans or programs you are enrolled in – pharmacy, dental or vision. It's easy to see what coverage you have!

Q: *Why does each family member get a separate I.D. card?*

A: By giving your family members their own card with their own name on it, Providers know right away that each family member is covered by the plan – even dependents. If someone in your family happens to forget the card, he or she can still use another family member's card.

Q: *How can I replace a lost I.D. card?*

A: Visit www.empireblue.com or call Member Services. By visiting us on-line, you can also print a temporary identification card for your immediate use.

Using Your PPO

Know the Basics

The key to using your PPO plan is understanding how benefits are paid. Start by choosing In-Network or Out-of-Network services any time you need healthcare. Your choice determines the level of benefits you will receive.

You can view and print up-to-date information about your plan or request that information be mailed to you by visiting www.empireblue.com.

USE YOUR PPO TO YOUR BEST ADVANTAGE

Your health is valuable. Knowing how to use your PPO to your best advantage will help ensure that you receive high quality healthcare – with maximum benefits. Here are three ways to get the most from your coverage.

- **BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN.** That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the plan applies to certain types of care.
- **PLEASE REMEMBER TO PRECERTIFY** hospital, Ambulatory Surgery (for Medically Necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. You'll recognize these services when you see this sign. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care – for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be denied.
- **ASK QUESTIONS** about your healthcare options and coverage. To find answers, you can:
 - Read this Guide.
 - Call Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply.

Talk to your Provider about your care, learn about your benefits and your options, and ask questions. Empire is here to work with you and your Provider to see that you get the best benefits while receiving the quality healthcare you need.

CHOOSING IN-NETWORK OR OUT-OF-NETWORK SERVICES

In-Network services are healthcare services provided by a doctor, hospital or healthcare facility that has been selected by Empire or another Blue Cross and/or Blue Shield plan to provide care to our members. When you choose In-Network care, you get these advantages:

- **CHOICE** – You can choose any participating Provider from the largest network of doctors and hospitals in New York State or the network of Blue Cross and Blue Shield PPO plans through the BlueCard PPO Program.
- **FREEDOM** – You do not need a referral to see a specialist, so you direct your care.
- **LOW COST** – Benefits are paid after a small Co-payment, deductible and/or coinsurance payment for office visits and many other services.
- **BROAD COVERAGE** – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home health care.
- **CONVENIENCE** – Usually, there are no claim forms to file.
- **Out-of-Network services** are healthcare services provided by a licensed Provider outside Empire's PPO network or the PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you can choose In-Network or Out-of-Network. However, some services are only available In-Network. When you use Out-of-Network services:
 - You pay an annual Deductible and coinsurance, plus any amount above the Allowed Amount (the maximum Empire will pay for a covered service); if you use a BlueCard provider you will pay the lower of billed charges or a negotiated rate and your member liability.
 - You will usually have to pay the Provider when you receive care
 - You will need to file a claim to be reimbursed by Empire

Appendix A

Here's an example of how costs compare for In-Network and Out-of-Network care.

	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>
PROVIDER'S CHARGE	\$500	\$500
ALLOWED AMOUNT	\$400	\$400
PLAN PAYS PROVIDER	\$370	\$320 (80% of Allowed Amount)
YOU PAY PROVIDER	\$20 Co-Payment (per visit)	\$180 (20% of Allowed Amount, plus the \$100 above the Allowed Amount. Assumes you have satisfied your Deductible)

*The following chart shows your specific plan information.
See the Details and Definitions section for explanations of terms in the chart.*

	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>
ANNUAL DEDUCTIBLE (combined In-Network and Out-of-Network)	\$0/Individual \$0/Family	\$200/Individual \$800/Family
MEDICAL CO-PAYMENT (for office visits and certain Covered Services)	\$20 Co-Payment (per visit)	N/A
CO-PAYMENT (for hospital inpatient admissions)	\$0	N/A
CO-PAYMENT (for emergency room) (Facility)	\$50 Co-Payment (per visit) (waived if admitted to hospital within 24 hours)	\$50 Co-Payment (per visit) (waived if admitted to hospital within 24 hours)
COINSURANCE		You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
HOSPITAL (Facility)	\$0	
MEDICAL (Services)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above the allowed amount
LIFETIME MAXIMUM	Unlimited	Unlimited

Appendix A

HOW TO ACCESS PRIMARY AND SPECIALTY CARE SERVICES

Your health plan covers certain primary and specialty care services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

To make an appointment call your physician's office:

- Tell them you are an Empire member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

WHEN YOU NEED CARE AFTER NORMAL OFFICE HOURS

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

WHERE TO FIND NETWORK PROVIDERS

Empire's PPO network gives you access to Providers within the plan's Operating Area of 28 eastern New York State counties. See "Operating Area" in the Health Care Terms and Definitions section for a listing of counties.

To locate a Provider in Empire's Operating Area, visit www.empireblue.com. You can search for Providers by name, address, language spoken, specialty and hospital affiliation.

You can also request that a directory be mailed to you free of charge by calling Member Services at 1-800-553-9603.

TRANSITIONAL CARE

Networks grow and change, and sometimes a provider will move or leave the network that serves your Plan. 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 physician's termination or within 15 days after we become 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) to adhere to the plan's quality assurance requirements, (3) to provide the plan with necessary medical information related to this care, and (4) to adhere to the plans 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 our 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 health care professional's ability to practice.

New plan members 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. Members 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) to adhere to the plan's quality assurance requirements, (3) to provide the plan with necessary medical information related to this care, and (4) to adhere to the plans policies and procedures, in both situations. You must contact our Medical Management department to arrange this continued care.

Inter-Plan Programs

Out-of-Area Services

Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of Empire’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Empire and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Empire’s service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare providers. Empire’s payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Empire’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Empire’s Service Area

Your Liability Calculation

When covered healthcare services are provided outside of Empire’s service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue’s nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, Empire may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Empire will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the covered services as set forth in this paragraph.

BlueCard® PPO Program

Care When you are Out of Our Service Area Within the U.S.

If you are traveling outside the Empire service area, the BlueCard® PPO program lets you use other Blue Cross and/or Blue Shield plans' PPO networks of physicians, hospitals and other health care providers. As a PPO member, you are automatically enrolled in the BlueCard® PPO program. This allows you to receive in-network benefits across the country outside of our network area from providers participating with other Blue Plans' PPO networks. As long as these services are covered services under your Contract or Certificate, they will be treated as in-network services. If you are traveling and need medical care, call 1-800-810-BLUE (2583), for the names and addresses of the PPO providers nearest you. You may also visit the Blue Cross and Blue Shield Association Web site to locate providers in other states at www.bcbs.com.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides hospital and professional coverage through an international network of healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct^{®1} Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the maximum allowed amount.

Your Benefits At A Glance

Empire’s plan provides a broad range of benefits for you and your family. Following is a brief overview of your PPO coverage. See the Coverage section for more details. **In general, the applicable deductible is \$200 per individual with a maximum of \$800 per family when you utilize providers that are out-of-network. The applicable co-insurance is 20%.** When reviewing this summary, please remember to refer to the applicable footnotes (e.g. (1), (2), (3), (4) (5) or (6) for each benefit. These notes are set forth at the end of this summary of benefits.

FACILITY SERVICES

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>IN-HOSPITAL CARE (4)</u>		
Semi-Private Room and Board (4) (including ancillaries)	\$0	You pay Deductible/20% Co-Insurance /plus any amount above the allowed amount
Intensive Care Unit (4) (including ancillaries)	\$0	You pay Deductible/20% Co-Insurance /plus any amount above the allowed amount
Emergency Room (initial visit per occurrence)	\$50 Co-Payment per visit (waived if admitted to the same hospital within 24 hours)	
Ambulatory Surgery (4)	\$0	You pay Deductible/20% Co-Insurance /plus any amount above the allowed amount
Pre-Admission / Pre-Surgical Testing (must be within 7 days of a scheduled surgery in the same hospital)	\$0	You pay Deductible/20% Co-Insurance /plus any amount above the allowed amount
Kidney Dialysis	\$0	You pay Deductible/20% Co-Insurance /plus any amount above the allowed amount
Chemotherapy / Radiation Therapy	\$0	You pay Deductible/20% Co-Insurance /plus any amount above the allowed amount

Appendix A

DOCTOR / MEDICAL SERVICES

IN OFFICE OR HOSPITAL - LICENSED PHYSICIAN SERVICES

The in-network medical co-pay will apply to examinations, evaluation & consultation services; in general, in-network co-insurance will be applied to other services received during the office visit with certain exceptions.

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
Office Visit	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Specialist Office Visit	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>CHIROPRACTOR CARE COVERAGE FOR MEMBER AND SPOUSE ONLY</u> (20 visits per calendar year combined In-Network and Out-of-Network)		
Spinal manipulation	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
All other services	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>ALLERGY SERVICE</u>		
Office Visits	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Allergy Testing	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Allergy Treatment	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Second/Third Surgical Opinion Office Visit (6)	\$20 Co-Payment per visit	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Diabetes Education/Management	\$20 Co-Payment per visit	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>SURGEON/ASSISTANT SURGEON</u>		
In office/out-patient or inpatient hospital	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount

For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount of the other procedure.

Appendix A

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
Emergency Room Doctors	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Anesthesiologist	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Chemotherapy/ Radiation Therapy	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>DIAGNOSTIC PROCEDURES</u>		
Lab Tests	\$0 Co-Payment	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
X-rays and Other Imaging Services	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Radium and Radionuclide Therapy	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
MRI's/MRA's (4), PET/CAT Scans (4), Nuclear Cardiology Services (4) and Echocardiogram (4)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Genetic Testing (4)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>ANNUAL PHYSICALS</u>		
One Routine Physical per Calendar Year	\$20 Co-Payment (all other services require Co-Insurance)	Not Covered ****

Appendix A

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>DIAGNOSTIC SCREENING TEST</u>		
Cholesterol (1 every 24 months up to age 35; after age 35 1 every 12 months)	\$0 Co-Payment	Not Covered ****
Diabetes	\$0 Co-Payment	Not Covered ****
Routine Prostate Specific Antigen (PSA) in asymptomatic males (Over age 50 1 every 12 months; Between ages 40-49 if risk factors exists – 1 every 12 months; If prior history of prostate cancer, PSA at any age)	\$0 Co-Payment	Not Covered ****
Diagnostic PSA (1 every 12 months)	\$0 Co-Payment	Not Covered ****
Colorectal Cancer (fecal occult blood test if age 40 or over 1 per calendar year)	\$0 Co-Payment	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Sigmoidoscopy (if age 40 or over 1 every 24 months)	\$0 Co-Payment	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Diagnostic	\$0 Co-Payment	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Biopsy	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount

**** Please refer to Section 3 of the Fund’s SPD for more information about self-insured benefits relating to annual physical examinations with Professional Evaluation Medical Group (PEMG).

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>WELL WOMAN CARE</u>		
Routine Office Visit	\$20 Co-Payment (all other services require coinsurance)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Pap Smear	\$0 Co-Payment	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Bone Density testing and treatment (Ages 52 through 64 – 1 baseline; Ages 65 and older – 1 every 24 months (If baseline before age 65 does not indicate osteoporosis); Under age 65 – 1 every 24 months (if baseline before age 65 indicates osteoporosis)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Mammogram (based on age and medical history)(Ages 35 through 39 – 1 baseline; Age 40 and older - 1 per year)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount

Appendix A

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>WELL CHILD CARE</u>		
NEWBORN	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
2 in-hospital exams at birth following vaginal delivery	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
4 in-hospital exams at birth following c-section delivery	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Office Visits (From birth up to 1 st birthday: 7 visits; Ages 1 through 4 years of age : 7 visits; Ages 5 through 11 years of age: 7 visits; Ages 12 up to 17 years of age: 6 visits; Ages 18 to 19 th birthday: 2 visits)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Certain Immunizations (office visits not required)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>MATERNITY CARE</u>		
Initial Prenatal and Postnatal Care (in Doctors office)	\$20 Co-Payment	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Obstetrical Care (Doctors charge for delivery)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Hospital Admission for Delivery (4) (facility charge)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
In Birthing Center (4) (facility charge)	\$0	Not Covered
<u>ROUTINE NEWBORN CARE</u>		
Routine Newborn Nursery (Facility)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Doctor's Services ***	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount

***with the exception of the newborn in-hospital exams at birth (refer to the Well Child Care Section)

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	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>REPRODUCTIVE SERVICES</u> <i>The combined lifetime maximum is for the contract holder and spouse. The lifetime maximum is \$12,500.00, subject to 80% coinsurance, \$10,000.00 total. Infertility prescriptions are part of this lifetime maximum, however you must submit prescription claims to Fund Office and the Fund Office will submit claim to Empire Blue Cross Blue Shield for processing.</i>		
Artificial Insemination	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Advanced Reproductive Technologies	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Infertility Drugs	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount

	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>PHYSICAL THERAPY (4)</u> <i>(Days/visits per calendar year are combined In-Network and Out-of-Network)</i>		
In-patient rehabilitation (4) (up to 30 days per calendar year)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Out-Patient Rehabilitation (4) (up to 30 days per calendar year; combined in home, office or out-patient facility)	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance / plus any amount above of the allowed amount
Occupational and speech therapy (4) (up to 30 visits per calendar year; combined, in-network and out-of-network)	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Vision Therapy (up to 30 visits per calendar year; combined, in-network and out-of-network)	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Cardiac Rehabilitation	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Skilled Nursing Facility (4) (up to 60 in-patient days per calendar year)	\$0	Not Covered
Hospice (Up to 210 days per lifetime; Treatment maximums are combined for In-Network and Out-of-Network care)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Home Health Care (Up to 200 visits per calendar year; Combined In and Out of Network; 1 visit equals four (4) hours of care)	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount

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	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>HOME INFUSION THERAPY</u>		
Home Health Care Agency Combined In and Out of Network Visits combined with Home Health Care	\$0	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Medical Provider	20% Co-Insurance	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
<u>MENTAL HEALTH CARE</u>		
Doctor Service (outpatient/office visit)	\$20 Co-Payment (per visit)	You pay Deductible, 20% Co-Insurance /plus any amount above of the allowed amount
Inpatient Hospital (5) (facility)	\$0	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Mental Health Professional (inpatient hospital visits)	\$0	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
<u>ALCOHOL/SUBSTANCE ABUSE TREATMENT</u>		
In-Patient Detoxification (5)	\$0	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
In-Patient Rehabilitation (5)	\$0	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Out-patient Visits (Medically necessary visits including visits for family counseling)	\$0	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
<u>DURABLE MEDICAL EQUIPMENT</u>		
Durable Medical Equipment (4) (i.e. hospital type bed, wheelchair, etc.)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Orthotics (4)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Prosthetics (4) (i.e. artificial arms, legs, eyes, ears)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Hearing Aids (once every 3 calendar years for purchase of hearing aids from HearUSA 1-800-700-3277)	\$0	Not covered by Empire; refer to the Fund's SPD Section 3

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	IN-NETWORK (1)	OUT-OF-NETWORK (2,3)
<u>SUPPLIES</u>		
Medical Supplies (i.e. catheters, oxygen, syringes)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Nutritional Supplements (i.e. enteral formulas and modified solid food products)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
<u>OTHER COVERED SERVICES</u>		
Lasik Surgery (In-Network and Out-of-Network)	Maximum of \$1,000.00 per eye The provider may balance bill you over the maximum allowed	
Sleep Apnea Testing	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
CPAP Machine (4)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Ambulance – when medically necessary (local professional ground ambulance to the nearest hospital)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount
Air Ambulance – when medically necessary (Precertification (4) required if scheduled)	20% Co-Insurance	You pay Deductible, 20% Co-Insurance plus any amount above of the allowed amount

1. Network provider delivers care. The In-Network office Co-Payment applies to examinations and evaluations only. Other services performed at the office setting may be subject to the Co-Insurance.
2. Out-of-Network services (except Mental Health Care and Alcohol/Substance Abuse Care – see footnote 5) are those from a provider that does not participate in Empire’s PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.)
3. Out-of-Network (O-O-N) providers – those who do not participate in Empire’s PPO network or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-Network providers, who do not participate with Empire or with another Blue Cross and Blue Shield Plan, will be reimbursed at the in-network rate and the provider may balance bill you over Empire’s allowed amount.
4. You are responsible for obtaining precertification from Empire Blue Cross Blue Shield Medical Management for these services provided in-area and out-of-area, In-Network and Out-of-Network. Your provider may call for you. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
5. You are responsible for obtaining precertification from Empire’s Behavioral Healthcare Management for these services. Your provider may call for you.
6. In-Network office Co-Pay applies to Second Surgical Opinion visit unless waived by Empire Blue Cross Blue Shield Medical Management. Co-Insurance may apply to other services performed at the office setting.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Medical Management Program requirements could result in benefit reductions.

Customer Service Toll Free: 1-800-553-9603

Address for Out-of-Network Claims (In-Network providers bill Empire directly)

Empire Blue Cross Blue Shield
P.O. Box 1407
Church Street Station
New York, N.Y. 10008-1407
Attn: Claims Department

Coverage

Doctor's Services

When you need to visit your doctor or a specialist, Empire makes it easy. In-Network, you pay only a small Co-payment, and/or a Co-insurance, where applicable. 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 done in the doctor's office or a network facility. For In-Network allergy testing, there is a 20% co-insurance. In-Network visits for ongoing allergy treatment are covered in full.

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

Tips For Visiting Your Doctor

- When you make your appointment, confirm that the doctor is an Empire network Provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to an outside lab or radiologist for tests or X-rays, call Member Services to confirm that the supplier is in Empire's network.

What's Covered

Covered Services are listed in *Your Benefits at a Glance* section. 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 appurtenances, and insulin infusion devices
 - Other equipment and supplies required by the New York State Health Department
 - 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
 - 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.
 - Home visits for education when Medically Necessary
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Chiropractic Care
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Hearing aids and the examination for their fitting once every three (3) calendar years for the purchase of hearing aids from a HearUSA. HearUSA is one of the nation's most respected hearing care Providers and the only one accredited by the Joint Commission on Accreditation of Healthcare Organizations. HearUSA has 80 centers in Florida, New Jersey and New York. Please consult the Fund Office for other Providers. To this end, please refer to Section 3 in the Fund's SPD.

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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 – Please refer to Section 3 of the Fund's SPD
- Routine hearing exams, except as described under hearing aids above
- 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
- Services given by an unlicensed Provider or performed outside the scope of the Provider's license
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition.

Emergency Care

IF YOU NEED EMERGENCY CARE

Should you need emergency care, your plan is there to cover you. Emergency care is covered in the hospital emergency room.

To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy
- Cause serious problems with your body functions, organs or parts
- Cause serious disfigurement
- In the case of behavioral health, place others or oneself in serious jeopardy

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. With respect to an emergency medical condition, the term "Stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta).

Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call 24/7 Nurse Line at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week.

Emergency Services Rendered by Out-of-Network Providers

Although the participating provider network offered under the Plan is designed to cover a broad range of service providers, please keep in mind that some providers in certain specialties including, and without limitation, anesthesia, radiology and pathology, do not participate In-Network even if you are receiving services from an In-network facility or hospital. On the Plan's website, you have the ability to search for an In-Network provider without charge. You can also contact Empire directly by calling 1-800-553-9603 to confirm whether a provider or specialist participates In-Network.

However, in certain emergency situations where there is no In-Network provider or specialist available for immediate treatment, upon filing an appeal, the Plan may authorize a negotiation on your behalf with regard to the balanced billed amount for such Out-of-Network services. 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 be required to pay the In-Network cost share amounts (deductible, co-insurance) for those Out-of-Network services. Although the Plan may negotiate the balanced billed amount for the Out-of-Network claim(s) that may be billed under these circumstances, you may remain liable for the difference between the Maximum Amount Allowed (i.e., the applicable coinsurance under Empire's In-Network PPO rate) under the Plan and the Out-of-Network provider's charge for such services.

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As a reminder, the only time the Plan may negotiate is if the service is related to an emergency situation where you could not have selected an In-Network provider. If possible, you should always discuss billing procedures prior to receiving treatment from an Out-of-Network provider.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's PPO network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a Co-payment for a visit to an emergency room. This Co-payment is waived if you are admitted to the hospital within 24 hours.

Remember: You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

If you are admitted to the hospital, you or someone on your behalf must call Empire Blue Cross Blue Shield before services are rendered or within 48 hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from Empire Blue Cross Blue Shield within the required time and the admission or procedure is not Medically Necessary, benefits may be denied.

Tips For Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment
- If you have an emergency while outside Empire's service area anywhere in the United States, and the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard[®] PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room, and if you are admitted, notify Empire Blue Cross Blue Shield within 48 hours of admission. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard[®] Worldwide program, simply show your Empire I.D. card and call 1-800-810-BLUE (2583), or collect at 1-804-673-1177 if you are admitted. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide Program, you will need to file a claim.
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard[®] PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.

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 (and the need for treatment is not sudden and serious)
- Ambulette

Emergency Air Ambulance

We will provide 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
- 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 allowed amount and the total charges of an Out-of-Network provider. Remember to call Empire Blue Cross Blue Shield at 1-800-553-9603 within 48 hours or as soon as possible if transported by air ambulance.

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Emergency Land Ambulance

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

Benefit is subject to cost sharing obligations. Benefits are not available for transfers of covered members between healthcare facilities.

Maternity Care and Reproductive Services

IF YOU ARE HAVING A BABY

There are no out-of-pocket expenses after the initial office visit Co-payment for routine maternity and newborn care when you use In-Network Providers. That means you do not need to continue to pay a Co-payment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical cares in the hospital or birthing center, as well as routine newborn nursery care are all covered at 100% In-Network.

For Out-of-Network maternity services, you pay the Deductible, coinsurance and any amount above the Allowed Amount.

• Prenatal and postnatal care (In doctor's office)
• Lab tests, sonograms and other diagnostic procedures
• Routine newborn nursery care (In hospital)
• Obstetrical care (In hospital)
• Infertility treatment including drugs (Coverage for member and spouse only)
• Up to a lifetime maximum of \$12,500 @ 80%
• Obstetrical care (In birthing center)

Whether services are provided In-Network or Out-of-Network, call Empire Blue Cross Blue Shield at 1-800-553-9603 within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

Newborn Dependent Children (Special Rules for Coverage)

The Plan covers pregnancy and any pregnancy related treatment. In accordance with federal law including without limitation the Newborns' and Mothers' Health Protection Act of 1996, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours after childbirth for any delivery other than a cesarean section. Following a cesarean section delivery, the plan provides, at a minimum, coverage for a hospital stay of at least ninety-six (96) hours. Mother and newborn are automatically eligible for the above hospital lengths of stay following childbirth. If mother or newborn require an extended hospital stay, you must call Empire Blue Cross Blue Shield at 1-800-553-9603 immediately.

If mother or newborn decide to be discharged earlier than either forty-eight (48) hours after childbirth for any delivery other than a cesarean section, or ninety-six (96) hours following a cesarean section, mother or newborn are entitled, upon request made

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within that time period, to one home care visit. This visit will be made within twenty-four (24) hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits provided by the Plan. It is not subject to the deductible or coinsurance.

In addition to the foregoing, your newborn dependent child will be covered from the date of birth, provided you enroll that newborn dependent child for coverage within 90 days of birth. To do so, please contact the Fund within the applicable 90 day period. Otherwise, the dependent child will be covered from the first 30 days of birth. However, effective as of November 1, 2015, the Plan will cover services rendered to a newborn dependent child for the first 48/96 hours from their date of birth, regardless of whether you timely file the applicable enrollment information within the 90 day period. As such, effective as of November 1, 2015, all claims for services rendered for a newborn child after 48/96 hours from their date of birth will be denied, unless the enrollment (and the required documentation) is timely received by the Fund Office within the 90 day special enrollment period.

FUTURE MOMS PROGRAM

Empire understands that having a baby is an important and exciting time in your life, so we developed the Future Moms Program. Specially trained obstetrical nurses, working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth. And just as important, we're here to answer your questions.

While most pregnancies end successfully with a healthy mother and baby, Empire's Future Moms Program is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies. We can also provide home health care referrals and health education counseling.

Please let us know as soon as you know that you're pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in the Future Moms Program. Call 1-800-828-5891 and listen for the prompt that says "precertify." You will be transferred to the Future Moms Program.

Obstetrical care in the hospital or any In-Network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.

What's Covered

Covered Services are listed in Your *Benefits at a Glance* section. 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 (precertification is not required). 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. Call Empire Blue Cross Blue Shield to precertify the hospital stay.
- 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
- Private duty nursing

REMEMBER

Use a network obstetrician/gynecologist to receive the lowest cost maternity care.

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Reproductive Services/Infertility

Coverage is provided for artificial insemination and advanced reproductive technologies if you are infertile and unable to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. Benefits are limited to the member and spouse up to a \$12,500 Combined Lifetime Maximum including prescription drugs, subject to 80% coinsurance, \$10,000 total. For advanced reproductive technologies, network physicians must be members of, and contribute data to, the Society of Assisted Reproductive Technologies (SART).

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations.

Following are Covered Services and limitations:

- 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.

Medications necessary to the provisions above, including parenteral injection and oral ovulation induction drugs.

What's Covered

Following are Covered Services and limitations:

Three (3) cycles of advanced reproductive technologies, including:

- In-vitro Fertilization (IVF)
- Zygote Intrafallopian Transfer (ZIFT)
- Gamete Intrafallopian Transfer (GIFT)
- Intracytoplasmic Sperm Injection (ICSI)

Cycles obtained before becoming a member will count towards the three-cycle limitation. A cycle which is started but not completed is a dropped cycle. Dropped cycles, even if no transfer is performed, will count towards the number of cycles, as follows:

First covered cycle – three (3) dropped cycles will count as the first cycle
Second covered cycle – two (2) dropped cycles will count as the second cycle
Third covered cycle – two (2) dropped cycles will count as the third cycle

- Medically Necessary and appropriate diagnostic workup and radiology services.
- Infertility drugs will be covered by Empire Blue Cross Blue Shield up to the lifetime maximum. You must submit these claims to the Fund Office and the Fund Office will submit claim to Empire Blue Cross Blue Shield for processing.

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Pathology and laboratory services including:

- Hormonal assays
- Swim up semen analysis as appropriate
- Ultrasound exams
- Fertilization and embryo culture
- Ova retrieval
- Embryo, gamete-zygote transfer
- Embryo cryo preservation or associated fees
- Procurement of donor sperm from sperm bank
- Storage of previously frozen embryos
- Sperm procurement

Services must be Medically Necessary and must be received from eligible Providers as determined by Empire in accordance with applicable regulations of the New York State Insurance Department. In general, an eligible Provider is defined as a healthcare 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.

What's Not Covered

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

- Any procedure for which donated ova or donated sperm are used, except in connection with the artificial insemination benefit described above
- Costs associated with maternity services
- Reversal of elective sterilizations, including vasectomies and tubal ligations
- Cloning
- Medical or surgical services or procedures that are experimental.
- Services to diagnose or treat infertility if we determine, in our sole judgment, that the service was not Medically Necessary.
- Surrogacy and any associated fees
- Services requested which are not medically appropriate, including but not limited to, ovarian failure or obesity wherein the chances of successful pregnancy are substantially diminished
- Services not specifically listed as covered under this benefit

Hospital Care (Facility)

IF YOU VISIT THE HOSPITAL

When you use an In-Network hospital or facility your plan covers most of the cost of your Medically Necessary care for surgery or treatment of illness or injury. When you use an Out-of-Network hospital or facility, you pay the deductible and coinsurance, plus any amount above Empire's Allowed Amount.

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

- Are performed in a same-day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or Medically Necessary, and
- Would justify an inpatient hospital admission in the absence of a Same-Day Surgery program.

Remember to call Empire Blue Cross Blue Shield at 1-800-553-9603 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or surgical procedure, call Empire Blue Cross Blue Shield within 48 hours or as soon as reasonably possible. If you do not obtain authorization from Empire Blue Cross Blue Shield within the required time and the admission or procedure is not Medically Necessary, benefits may be denied.

When you use an In-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.

Tip For Getting Hospital Care

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

Inpatient and Outpatient Hospital Care

What's Covered

Covered Services are listed in *Your Benefits at a Glance* section. 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
- MRI's/MRA's, PET/CAT SCANS, Nuclear Stress Test, Echocardiogram when pre-approved by Empire Blue Cross Blue Shield (you or your provider must call to pre-certify this service.)
- Pre-Surgical Testing on an outpatient basis. Your tests have to be done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room

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 hospital stay is Medically Necessary
- Coverage is for unlimited days, subject to Empire Blue Cross Blue Shield, 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
- Breast cancer surgery (lumpectomy, mastectomy), including:
 - Reconstruction following surgery
 - Protheses
 - Surgery on the other breast to produce a symmetrical appearance
 - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

Appendix A

The patient has the right to decide, in consultation with the physician and Empire Blue Cross Blue Shield, the length of hospital stay following mastectomy surgery.

- Use of cardio graphic 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
- Facilities, services, supplies and equipment related to Medically Necessary medical care

Outpatient Hospital Care

What's Covered

Following are additional Covered Services for same-day care:

- Same-day and hospital outpatient surgical facilities
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department 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.
- 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:
 - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered)
 - In a hospital-based or free-standing facility. See “Hospital/Facility” in the Definitions section.

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
 - Infirmarys 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 Details and Definitions section.
- Residential Treatment Services

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

- Routine medical care including but not limited to:
 - Same-Day Surgery not precertified as Medically Necessary by Empire Blue Cross Blue Shield
 - Inoculation or vaccination
 - Drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow

Durable Medical Equipment and Supplies

IF YOU NEED EQUIPMENT OR MEDICAL SUPPLIES

Your plan covers the cost of Medically Necessary prosthetics, orthotics and durable medical equipment. In-Network and Out-of-Network Benefits and plan maximums are shown in *Your Benefits at a Glance* section.

The network supplier must precertify the rental or purchase by calling Empire Blue Cross Blue Shield at 1-800-553-9603. When using a supplier outside Empire's Operating Area through the BlueCard PPO Program, *you* are responsible for precertifying services. An Empire network supplier may not bill you for Covered Services. If you receive a bill from one of these Providers, contact Member Services at 1-800-553-9603.

Tip For Obtaining Special Medical Supplies

For prosthetics, orthotics and durable medical equipment be sure the network vendor knows the number to call for Empire Blue Cross Blue Shield for precertification.

What's Covered

Covered Services are listed in *Your Benefits at a Glance* section. Following are additional Covered Services and limitations:

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire Blue Cross Blue Shield, 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.
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare Provider must provide a written order.

What's Not Covered

The following equipment is not covered:

- Air conditioners or purifiers
- Humidifiers or dehumidifiers
- Exercise equipment
- Swimming pools
- False teeth
- Hearing aids (except as previously described on page A-19)

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

You receive coverage through Empire's PPO for inpatient care in a Skilled Nursing Facility (SNF) or Hospice. Skilled Nursing Facility (SNF) benefits are available for In-Network facilities only. Hospice care is covered In-Network or Out-of-Network and plan maximums are shown in *Your Benefits at a Glance* section.

In order to receive maximum benefits, please call 1-800-553-9603 to precertify skilled nursing and hospice care with Empire Blue Cross Blue Shield.

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 *Your Benefits at a Glance* section. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor provides:
 - A referral and written treatment plan,
 - A projected length of stay,
 - An explanation of the services the patient needs, and
 - The intended benefits of care.
- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other 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
 - Rest cures

Hospice Care

Empire covers up to 210 combined lifetime days In-Network and Out-of-Network of hospice care. 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 hospital, or at home, as long as it is provided by a hospice agency.

What's Covered

Covered Services are listed in *Your Benefits at a Glance* section. 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
 - Up to 14 hours of respite care in any week

Appendix A

Tips for Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility, ask your doctor or caseworker to see the Health Facilities directory.
- Empire Blue Cross Blue Shield will help direct you to a skilled nursing facility that provides the appropriate care. When selecting from among multiple facilities, you may want to consider:
 - Is the facility's location convenient to friends, relatives and doctors?
 - What size facility is most suitable? A large facility may have more activities; a smaller one may be more personal.
 - Are visiting hours convenient for friends and relatives?
 - Who directs your care? Does your doctor have privileges at the facility?
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

Home Health Care

IF YOU NEED HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You will incur no out of pocket expense when you use an In-Network Provider. For Out-of-Network home health care, you pay deductible, coinsurance, and any amount above the allowed amount. Out-of-Network agencies must be certified by New York State or have comparable certification from another state. Benefits and plan maximums are shown in Your *Benefits at a Glance* section.

Home infusion therapy, a service sometimes provided during home health care visits, is available. 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 Member Services at 1-800-553-9603.

What's Covered

Covered Services are listed in Your *Benefits at a Glance* section. Following are additional Covered Services and limitations:

- Up to 200 home health care visits per year, combined In-Network and Out-of-Network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three (3) visits).
- 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
 - 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

Physical, Occupational, Speech or Vision Therapy

IF YOU NEED THERAPY

You receive benefits through Empire's plan for physical, occupational, speech and vision therapy. Outpatient physical, occupational, speech and vision therapy services are available In-Network and Out-of-Network. Inpatient physical therapy can also be In-Network or Out-of-Network.

Please call OrthoNet at 1-800-553-9603 to precertify all physical, occupational, and speech therapy.

Tip for Receiving Therapy

- Ask for exercises you can do at home that will help you get better faster.

What's Covered

Covered Services are listed in Your *Benefits at a Glance* section. Following are additional Covered Services and limitations:

Appendix A

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

Outpatient care must be given at home, in a therapist's office or in an outpatient facility, inpatient therapy must be short-term.

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

What's Not Covered

The following therapy services are not covered:

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

IF YOU NEED BEHAVIORAL HEALTHCARE

At Empire we realize that your mental health is as important as your physical health. That's why we include behavioral healthcare benefits at little out-of-pocket cost. Your behavioral healthcare benefits cover inpatient and outpatient treatment for alcohol or substance abuse both In-Network and Out-of-Network. Mental healthcare is covered on an inpatient and outpatient basis In-Network and Out-of-Network.

To help ensure that you receive appropriate care, you need to precertify all inpatient behavioral healthcare services in advance. When you call the Behavioral Healthcare Management Program at 1-800-553-9603 to pre-certify services, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the Authorized Services.

If you do not call to precertify behavioral healthcare, or if you call but do not follow their recommended treatment plan, covered benefits **MAY** be denied.

REMEMBER



When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Healthcare Management Program at 1-800-553-9603 within 48 hours or as soon as is reasonably possible.

If you want to know if a Provider or facility is covered In-Network, call the Behavioral Healthcare Management Program and a counselor will connect you to a care manager, who can help you.

If you do not agree with a certification decision made by the Behavioral Healthcare Management Program, you can file an appeal. For more information see "Complaints, Appeals and Grievances pages A-49-A53 and/or Section 7 of the Fund's SPD.

Appendix A

Mental Health Care

What's Covered

In addition to the services listed in Your *Benefits at a Glance* section, the following mental health care service is covered:

- 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
- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management.
- Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law.

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 Your *Benefits at a Glance* section, 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 plan may receive medically necessary counseling visits.
- Out-of-Network outpatient treatment at a facility that:
 - Has New York State certification from the Office of Alcoholism and Substance Abuse Services
 - 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
- 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 Empire Blue Cross Blue Shield Plan does not cover the following:

Dental Services (Please refer to Section 6 of the Fund’s SPD for Dental and Orthodontia Benefits)

- 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
 - Orthognathic surgery that is dental in nature

However, your plan does cover:

- Treatment of sound natural teeth injured by accident if treated within 12 months of the injury

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire’s judgment are:
 - Experimental or investigative
 - 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
 - Not generally recognized by the medical community (as reflected in published medical literature)

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 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).
- 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
- Government hospital services, except:
 - Specific services covered in a special agreement between Empire and a government hospital
 - 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 Guide as available either at home or as an emergency.

Appendix A

Inappropriate Billing

- Services usually given without charge, even if charges are billed
- Services performed by hospital or institutional staff which 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 Definitions section for more information.

Prescription Drugs (Refer to Section 5 of the Funds' SPD for prescription benefits)

- 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.
- The only exception to the above is infertility related drugs will be covered by Empire Blue Cross Blue Shield however, you must submit these prescription claims to the Fund Office and the Fund Office will submit claim to Empire Blue Cross Blue Shield for processing.

The combined lifetime maximum is for the contract holder and spouse. The lifetime maximum is \$12,500.00, subject to 80% coinsurance, \$10,000.00 total. Infertility prescriptions are part of this lifetime maximum.

Sterilization/Reproductive Technologies

- Reversal of elective sterilizations, including vasectomies and tubal ligations

Travel

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

Eye Care (Refer to Section 3 of the Fund's SPD for eye care benefits)

- Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated

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 contract shall be deemed to create between Empire and any hospital, facility or Provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Empire will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a Hospital/Facility or from a Provider.

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 plan will pay. To help you manage your health, Empire Blue Cross Blue Shield provides the Empire’s Medical Management Program, a service that precertifies hospital admissions and certain treatments and procedures, to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

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

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

HOW EMPIRE’S MEDICAL MANAGEMENT PROGRAM HELPS YOU

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

- Reviews all planned and emergency hospital admissions.
- Reviews ongoing hospitalization.
- Performs case management.
- Coordinates discharge planning.
- Coordinates purchase and replacement of durable medical equipment, prosthetics and orthotic requirements.
- Reviews inpatient and ambulatory surgery.
- Reviews high-risk maternity admissions.
- Reviews care in a hospice or skilled nursing or other facility.

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

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

<i>CALL TO PRECERTIFY ...</i>	<i>HOW COVERED</i>	<i>WHO CALLS TO PRECERTIFY</i>
<p><i>ALL HOSPITAL ADMISSIONS</i></p> <p><i>At least two weeks prior to any planned surgery or hospital admission</i></p> <p><i>Within 48 hours of an emergency hospital admission, or as soon as reasonably possible</i></p> <p><i>For illness or injury to newborns</i></p>	<p><i>In-Network and Out-of-Network</i></p>	<p><i>YOU</i></p>
<p><i>MATERNITY CARE</i></p> <p><i>Within the first three months of a pregnancy</i></p>	<p><i>In-Network and Out-of-Network</i></p>	<p><i>YOU</i></p>

Appendix A

CALL TO PRECERTIFY ...	HOW COVERED	WHO CALLS TO PRECERTIFY
<p>BEFORE YOU RECEIVE</p> <p><i>Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification</i></p> <p><i>Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs</i></p> <p><i>Inpatient and outpatient physical, occupational, and speech therapy</i></p> <p><i>Same-Day Surgery for Medically Necessary cosmetic/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures</i></p> <p><i>MRI or MRA (A magnetic resonance imaging or magnetic resonance angiography scan)</i></p> <p><i>CAT/PET Scans</i></p> <p><i>Nuclear Stress Test</i></p> <p><i>Echocardiogram</i></p> <p><i>Genetic Test</i></p> <p><i>Scheduled air ambulance service</i></p> <p><i>Durable Medical Equipment</i></p>	<p><i>In-Network and Out-of-Network</i></p>	<p><i>YOU</i></p>
<p>BEFORE YOU RECEIVE</p> <p><i>Skilled nursing facility care</i></p>	<p><i>In-Network only</i></p>	<p><i>YOU</i></p>

REMEMBER

When you call the Medical Management Program to precertify services, you receive maximum benefits and helpful advice about your options

Appendix A

IF SERVICES ARE NOT PRECERTIFIED

If you call to precertify services as needed, you will receive maximum benefits. If you do not obtain authorization from Empire Blue Cross Blue Shield within the required time and the admission or procedure is not Medically Necessary, benefits may be denied. This benefit reduction may also apply to 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.

Tips for Precertifying Services with Empire's Medical Management

- Have the following information about the patient ready when you call:
 - Name, birth date and sex
 - Address and telephone number
 - Empire I.D. card number
 - Name and address of the Hospital/Facility
 - Name and telephone number of the admitting doctor
 - Reason for admission and nature of the services to be performed
- When the vendor or Provider is required to call Empire's Medical Management Program for precertification, be sure they know about the precertification requirement and that they have Empire's Medical Management telephone number.

Initial Decisions

Empire will comply with the following timeframes set forth in Section 7 of the Fund's SPD with regard to processing precertification, concurrent and retrospective review of requests for health care or hospitalization services.

- *Precertification Requests.* Precertification means that you must contact Empire's Medical Management Program for approval before you receive certain health care services. Your request will be reviewed for precertification within five (5) calendar days of receipt of the necessary information but not to exceed 15 calendar days from the receipt of the request. If there is not enough information to make a decision within five (5) calendar days, you will be notified in writing of the additional information needed, and you and your Provider will have 45 calendar days to respond. A decision will be made within 15 calendar days of receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.
- *Urgent Precertification Requests.* If the need for the service is urgent, a decision will be made as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of receipt of the request. If the request is urgent and requires further information to make a decision you will be notified within 24 hours of receipt of the request and you and your Provider will have 48 hours to respond. A decision will be made within 48 hours of receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response. If the information is not provided within that time your claim will be denied.
- *Concurrent Requests.* Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. All concurrent reviews of services will be completed within 24 hours of receipt of the request.
- *Retrospective Requests.* Retrospective review is conducted after you receive medical services already provided within 30 calendar days of receipt of the claim. If there is not enough information to make a decision within 30 calendar days, you will be notified in writing of the additional information needed, and you and your Provider will have 45 calendar days to respond. A decision will be made within 15 calendar days of receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response

IF A REQUEST IS DENIED

All denials of benefits 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 Medical Management will send you and your doctor with the reasons for the denial. You will have the right to appeal. Refer to section "Complaints, Appeals and Grievances" 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 their decision. A response will be provided by telephone and in writing within one business day of making the decision.

Appendix A

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 Blue Cross Blue Shield. 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
- Send us 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 your 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

IF YOU NEED ADDITIONAL SUPPORT FOR SERIOUS ILLNESS

Empire Blue Cross Blue Shield'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 Blue Cross Blue Shield's nurses can help you and your family:

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

A Case Manager serves as a single source for patient, provider, and insurer – 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
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Empire Blue Cross Blue Shield's 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 plan is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact Empire Blue Cross Blue Shield at 1-800-553-9603.

Healthy Living Programs

PREVENTIVE CARE

Preventive care is an important and valuable part of your healthcare. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why your plan provides many preventive care services for free or only a small Co-payment when you use network Providers.

For more information on staying healthy, be sure to check the My Health section of www.empireblue.com. There you'll find the latest information on hundreds of topics ranging from nutrition to stress management to children's immunization guidelines.

Tips For Using Preventive Care

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- 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.
- Keep your children healthy by getting routine checkups and preventive care, including certain immunizations.

What's Covered

Covered Services are listed in Your *Benefits at a Glance* section. Following are additional Covered Services and limitations:

- Well-woman care visits to a gynecologist/obstetrician
- 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:
 - 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)
- Coverage shall be available for individuals meeting the criteria of those 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
 - Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.
- 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.
- Well-child care immunizations as listed:

– DPT (diphtheria, pertussis and tetanus)	– Tetanus-diphtheria
– Polio	– Pneumococcal
– MMR (measles, mumps and rubella)	– Meningococcal Tetramune
– Varicella (chicken pox)	– Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives
– Hepatitis B Hemophilus	

What's Not Covered

These preventive care services are not covered:

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

360° Health[®] – Empire’s Health Services Programs

EMPIRE’S HEALTH SERVICES PROGRAM, 360° HEALTH[®], HELPS YOU IMPROVE, MANAGE AND MAINTAIN YOUR HEALTH.

No matter what your healthcare needs, as an Empire plan member you have access to programs and services to help you achieve and maintain your highest potential for good health—at no additional charge. 360° Health is a group of programs that surround you with personalized support. From preventive care to managing complex conditions, we are there when you need us.

Empire’s 360° Health is organized into:

- Online health and wellness resources.
- Discounts on health-related products & services, and alternative therapies
- Guidance and support for when you need help

The following are descriptions of some of the programs and services available to you:

24/7 Nurse Line and Audio Health Library – receive immediate assistance from a registered nurse, toll-free, 24-hours, 7-days-a-week. Simply call 1-877-Talk-2-RN (1-877-825-5276). If you need advice on comforting a baby in the middle of the night or need to locate a doctor, we’ll be there. Call us to:

- Assess and understand your symptoms.
- Find additional help to make informed healthcare decisions.
- Locate a doctor, hospital or other practitioner.
- Get information about an illness, medication or prescription.
- Find information about a personal health issue such as diet, exercise or high blood pressure
- Answer questions on pregnancy
- Get assistance with discharge from a hospital
- Help you decide if a medical situation requires emergency treatment.

You can also access an easy-to-use audio library. You’ll hear advice and news delivered in English and Spanish on several topics—from colds and sore throats to diabetes and cancer. Please refer to the back of this booklet for a list of recorded topics.

24/7 Nurse Line is not for emergencies, so please do not call if you believe you or a family member

- Is having a heart attack or stroke
- Is severely injured
- Is unable to breathe
- May have ingested poisonous or toxic substances
- Is unconscious.

In these cases, call 911 or your local emergency service as soon as possible.

Here’s how to use 24/7 Nurse Line:

- Dial 1-877-Talk-2-RN (1-877-825-5276) and follow the prompts to speak with a nurse or listen to the audiotope messages.
- The back of this booklet contains a complete listing of audiotope messages. Note the code number to the left of the topic(s) that you want to listen to, as you will be prompted for the number.
- If you have additional questions after listening to a tape, simply connect to the on-duty nurse.

Special Offers – Members may receive discounts on alternative medicine therapies and other health services. Go to the “Members” section of www.empireblue.com, look under Health Information, then select “360° Health”, and click on “Special Offers”.

Please note that these services and products may not be available to your group and in all states, and are not covered benefits under your Empire healthcare plan. Empire makes no payment for these value-added programs available to you. Members pay the full amount of the provider’s discounted fee.

Empire does not endorse or warrant these discounted services and products in any way. Empire reserves the right to change, amend or withdraw any and all discount programs or services at any time without notice to any party.

Member Newsletter – Our semi-annual member newsletter, *Healthy Solutions*, contains a variety of articles on staying healthy and coping with chronic diseases such as diabetes and asthma as well as helpful information about your health plan.

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Preventive Healthcare Guidelines – Distributed both in our member newsletter and available online at www.empireblue.com, these guides can help you and your family stays up-to-date on check-ups, immunizations, screenings and tests throughout every stage of your life.

My Health, powered by WebMD – this vast one-stop resource center of health information, services and tools is accessible to all eligible members through Member Online Services at www.empireblue.com. You'll be able to find out if you are at risk for certain conditions, access the latest in health news, learn about treatments for common conditions and diseases, and much more. You'll also find preventative healthcare guidelines including the important tests to take and discuss with your doctor. Topics include an online fitness program, LEAP (Lifetime Exercise Adherence Program), where you can create your own personal fitness routine; Ready, Set, Stop!, a smoking cessation program that blends conventional smoking cessation techniques with an interactive experience; and the Nutrition Center, where you can increase your understanding of your diet and find ways to improve its nutritional value.

Here's how to get to "My Health":

- Go to www.empireblue.com.
- Register or log on to Member Online Services.
- Click on "My Health" at the top of the screen.

Details and Definitions

In this section, we'll cover the details you need to know to make the plan work for you. Use it as a reference to understand:

- How to file a claim and get your benefits paid
- Reimbursement for Covered Services
- Complaints, Appeals and Grievances
- Your Rights and Responsibilities
- Our Confidentiality Policy
- HIPAA Privacy Requirements
- Health Care Terms and Definitions
- Audio Health Library Topics

Knowing the details can make a difference in how satisfied you are with your plan, and how easy it is for you to use. If you have additional questions, please visit www.empireblue.com or call Member Services at 1-800-553-9603.

How to File a Claim and Get Your Benefits Paid

IF YOU NEED TO FILE A CLAIM

Empire makes healthcare easy by paying Providers directly when you stay In-Network. Therefore, when you receive care from Providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for Covered Services received Out-of-Network, from a non-participating Provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service. Your PPO, or Preferred Provider Organization is a group healthcare plan administered by Empire Blue Cross Blue Shield.

<i>TYPE OF CLAIM</i>	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK</i>
<i>HOSPITAL</i>	<i>Provider files claim directly with Empire or local Blue Cross/Blue Shield plan</i>	<i>Provider files claim with Empire or local Blue Cross/Blue Shield plan*</i>
<i>MEDICAL</i>	<i>Provider files claim directly with Empire or local Blue Cross/Blue Shield plan</i>	<i>You file claim with Empire within 1 year of the date of service</i>
<i>AMBULANCE CHARGES</i>	<i>Provider files claim directly with Empire or local Blue Cross/Blue Shield plan</i>	<i>You file claim with Empire within 1 year of the date of service</i>

*At some out-of-area and non-participating hospitals, you may have to pay the hospital's bill. If this happens, include an original itemized hospital bill with your claim.

Send completed forms to:

Hospital Claims:

**Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional Claims Department**

Medical Claims:

**Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Medical Claims Department**

Want more claim information? Now you can check the status of a claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting www.empireblue.com.

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Tips for Filing a Claim – Refer to Section 7 of the Fund’s SPD for more information on the procedures on filing claims for benefits and appeals.

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

REMEMBER

File claims within one (1) year of the date of service (the date that charges were incurred) to receive benefits from the PPO!

Termination of Healthcare Coverage for Cause, including Fraud or Intentional Misrepresentation

The Plan reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded (within the meaning of Affordable Care Act) retroactively (as opposed to prospectively) except in the circumstances permitted by law, such as the failure to pay premiums or the commission of fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Plan administrator or its delegates) by you, your covered dependent(s), or someone seeking coverage on your behalf. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days’ notice. Failure to inform the Fund Office that you or your dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation.

REMEMBER

FRAUD HOTLINE 1-800-I.C.FRAUD (423-7283) During normal business hours

If You Have Questions About a Benefit Payment

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

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

The notification will give you:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary
- An explanation of the Fund’s claims review procedures

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

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

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If your question concerns behavioral healthcare, call (800) 553-9603 or write to:

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

If your claim is denied, you will have the right to appeal. See Section 7 in the Fund's SPD for more information about your appeal rights and the procedures to file an appeal and/or "Complaints, Appeals and Grievances" section pages A-49-A-53.

Reimbursement For Covered Services

Maximum Allowed Amount

This section describes how we determine 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 Blue Cross and Blue Shield 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:

- Maximum Allowed Amount of reimbursement is the same for In-Network and Out-of-Network Providers.
- that meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met 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, We 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 our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim submitted was inconsistent with procedure coding rules and/or our 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, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount will be the same whether the Provider is an In-Network Provider or an Out-of-Network Provider.

For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Empire to accept as reimbursement for the Covered Services. Because In-Network Providers 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

Appendix A

Amount to the extent that you have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit www.empireblue.com.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross and Blue Shield 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 will be the same as an In-Network Provider. The Maximum Allowed Amount for an In-Network Provider may be accessed by calling the Customer Service number on the back of your identification card. The Maximum Allowed Amount has been developed by reference to one or more of several sources, including the following:

1. Amounts based on our In-Network Provider fee schedule/rate;
2. Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
3. Amounts based on charge, cost reimbursement or utilization data;
4. Amounts based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable Providers' fees and costs to deliver care; or
5. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.

Providers who are not contracted for this Plan, but contracted for other Plans with Us, are also considered Out-of-Network. The Maximum Allowed Amount reimbursement for services from these Providers will be based on our In-Network Provider fee schedule/rate as described above.

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

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

MEMBER COST SHARE

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

Your cost share amount and 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 terms of this Benefit Booklet and Benefits At A Glance chart for your cost share amounts and limitations, or call Customer Service to learn how Your Plan's benefits or cost share amounts may vary by the type of Provider you use.

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

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Although the participating provider network offered under the Plan is designed to cover a broad range of service providers, please keep in mind that some providers in certain specialties including, and without limitation, anesthesia, radiology and pathology, do not participate In-Network even if you are receiving services from an In-network facility or hospital. On the Plan's website, you have the ability to search for an In-Network provider without charge. You can also contact Empire directly by calling 1-800-553-9603 to confirm whether a provider or specialist participates In-Network.

However, in certain emergency situations where there is no In-Network provider or specialist available for immediate treatment, upon filing an appeal, the Plan may authorize a negotiation on your behalf with regard to the balanced billed amount for such Out-of-Network services. 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 be required to pay the In-Network cost share amounts (co-insurance) for those Out-of-Network services. Although the Plan may negotiate the balanced billed amount for the Out-of-Network claim(s) that may be billed under these circumstances, you may remain liable for the difference between the Maximum Amount Allowed (i.e., the applicable coinsurance under Empire's In-Network PPO rate) under the Plan and the Out-of-Network provider's charge for such services.

As a reminder, the only time the Plan may negotiate is if the service is related to an emergency situation where you could not have selected an In-Network provider. If possible, you should always discuss billing procedures prior to receiving treatment from an Out-of-Network provider.

AUTHORIZED SERVICES

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, We 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 us in advance of obtaining the Covered Service. We 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 state and federal regulations on Emergency Services. If we authorize 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.

Complaints, Appeals and Grievances

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

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

STANDARD LEVEL 1 APPEALS

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

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

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

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

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

As a reminder, the Plan is subject to and governed by ERISA. As a result, you have certain rights and protections under the Plan for appealing claims. If your claim is denied, please also see Section 7 in the Fund's SPD for more information about your appeal rights and the procedures to file an appeal. If there is a conflict between the Fund's SPD and the terms of the applicable certificate of insurance booklet with regard to filing claims and appeal rights, the terms of the Fund's SPD will control.

The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision. The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments.

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

EXPEDITED LEVEL 1 APPEALS

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

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

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

- Empire will provide the Covered Person or his Provider with reasonable access to our clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone or fax.
- Empire will make a decision on an expedited appeal within the lesser of seventy-two (72) hours of receipt of the appeal request or two (2) business days following receipt of all necessary information about the case, but in any event within seventy-two (72) hours of receipt of the appeal.
- Empire will notify the Covered Person and his Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within twenty-four (24) hours after the decision is made.
- If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection or through an external appeal agent if the appeal is based on Medical Necessity or Experimental or Investigational denials. The notice of appeal determination will include the time frame for external appeals as required by law. .
- If Empire does not make a decision within two (2) business days of receiving all necessary information to review the Covered Person’s appeal, Empire will approve the service.

STANDARD LEVEL 2 APPEALS

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

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

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

HOW TO REQUEST AN APPEAL

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

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

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Send appeals concerning behavioral health care to:

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

Upon completion of the above appeals process, if you are still not satisfied by the decision made by Empire Blue Cross Blue Shield you can appeal in writing to the Board of Trustees enclosing documents, records and other information relating to the claim.

Health and Benefit Fund of the I.U.O.E.
Local Union 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036
Attn: Board of Trustees

COMPLAINTS

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

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

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

We will resolve complaints within the following time frames:

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

Upon completion of the above appeals process for Behavioral Health, if you are still not satisfied by the decision made by Empire Blue Cross Blue Shield you can appeal in writing to the Board of Trustees enclosing documents, records and other information relating to the claim.

Health and Benefit Fund of the I.U.O.E.
Local Union 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036
Attn: Board of Trustees

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LEVEL 1 GRIEVANCE

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

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

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

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

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

LEVEL 2 GRIEVANCES

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

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

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

EXPEDITED GRIEVANCES

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

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

DECISION ON GRIEVANCES

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

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

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans

HOW TO FILE A GRIEVANCE

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

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

Send appeals concerning behavioral health care to:

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

Upon completion of the above grievance process, if you are still not satisfied by the decision made by Empire Blue Cross Blue Shield you can appeal in writing to the Board of Trustees enclosing documents, records and other information relating to the claim.

Health and Benefit Fund of the I.U.O.E.
Local Union 94-94A-94B, AFL-CIO
337 West 44th Street
New York, NY 10036
Attn: Board of Trustees

HOW YOU CAN PARTICIPATE IN POLICY DEVELOPMENT

We welcome your input on policies that we have developed or you would like us to initiate. If you wish to share any ideas with us, we encourage you to write to us at:

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

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

PROVIDER QUALITY ASSURANCE

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

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

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- The member has the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person acting on the member's behalf.

You have the responsibility to:

- Choose a participating physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Our Confidentiality Policy

1. CONFIDENTIALITY POLICY

In recognition of the need for member privacy, and in compliance with federal and state laws and regulations, Empire has a policy on the confidentiality of member medical information.

- Empire has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of member medical information, which is used, disclosed, exchanged or transmitted orally, in writing or electronically.
- Confidential member medical information is accessible only to those Empire employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Empire policies and procedures and federal and state laws and regulation concerning the request for use, disclosure, transmission, release, security, storage and destruction of confidential member medical information.
- Empire does not disclose our members' nonpublic personal information to any of our affiliates or to nonaffiliated third parties, except as permitted by law to allow us to conduct our business.
- Disclosure of confidential information to external vendors for purposes of payment or health care operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect member identification.
- Identifiable personal health information is not shared with your Fund, unless permitted or required by law.
- Because Empire is not a Provider of medical services, it generally does not maintain medical records created by your Provider of service. If you require access to your Provider's medical records, please contact your Provider to arrange access.
- Empire contractually requires all of its network practitioners and Providers to ensure the privacy and to protect the confidentiality of members' medical information.
- When you become covered under your Empire health benefit plan, you agree that Empire, or its designee, may use and/or disclose your confidential medical information for purposes of payment and healthcare operations as permitted or required by law or regulation. In addition, each Empire member agrees that any healthcare Provider, healthcare payer or government agency shall furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made for use and/or disclosure by Empire to administer the terms of the health benefit plan.
- You may request access to any other information that is maintained by or for Empire by calling Member Services to arrange access. You may request an amendment of records maintained by and for Empire, or you may request an accounting of disclosures as permitted by law.
- Except as stated above and as may be permitted or required by law, Empire does not release confidential member medical information to anyone outside Empire without a specific "written authorization" to release, authorized by the member or member's designee, which may be revoked at any time. The authorization must be signed and dated and must specify:
 - The information that can be disclosed and to whom
 - What the information will be used for, and
 - The time period for which the authorization applies.

For additional information regarding the confidentiality of member medical information, please read Empire's Notice of Privacy Practices. Go to www.empireblue.com and click on "Privacy" at the bottom of the homepage. If you would like a printed copy of this policy please call Empire Member Services at the toll-free number on your identification card.

HIPAA Privacy Requirements

EMPLOYER/SPONSOR

1. Under the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations (45 C.F.R. Parts 160 and 164), referred to as HIPAA, the Employer/Sponsor of a Group Health Plan (the “Plan”) may obtain and use a member’s summary information¹ for purposes of obtaining premium bids, to modify, amend or terminate the Plan, and for enrollment and eligibility determinations.

Under the requirements of HIPAA, the Employer/Sponsor may obtain and use a member’s Protected Health Information, including electronic protected health information (PHI)², for purposes of Plan Administration. Prior to receiving PHI, the Employer/Sponsor shall certify to the Plan that the Plan Documents meet the requirements of HIPAA (as described below).

EMPLOYER/SPONSOR OBLIGATIONS

2. The Employer/Sponsor agrees to comply with the following in order to obtain PHI about members for the permissible limited uses or disclosures for the Plan administration functions it performs.

Purpose of Disclosure to Employer/Sponsor

- (a) The Plan and any health insurer or HMO will disclose members’ PHI to the Employer/Sponsor only to permit the Employer/Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Employer/Sponsor of members’ PHI will be subject to and consistent with the provisions of this section.
- (b) Neither the Plan nor any health insurance issuer or HMO will disclose members’ PHI to the Employer/Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the members.
- (c) Neither the Plan nor any health insurance issuer or HMO will disclose members’ PHI to the Employer/Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Employer/Sponsor.

Restrictions on Plan Sponsor’s Use and Disclosure of PHI

3.
 - (a) The Employer/Sponsor will neither use nor further disclose members’ PHI, except as permitted or required by the Plan Documents, as amended or required by law.
 - (b) The Employer/Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI.
 - (c) The Employer/Sponsor will ensure that any agent, including any subcontractor, to whom it provides members’ PHI, agrees to these restrictions and conditions, including implementing reasonable and appropriate security measures in the Plan Documents, with respect to members’ PHI.
 - (d) The Employer/Sponsor will not use or disclose members’ PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Employer/Sponsor.
 - (e) The Employer/Sponsor will report to the Plan any use or disclosure or security incident of members’ PHI that is inconsistent with the allowed uses and disclosures promptly upon learning of such inconsistent use or disclosure.
 - (f) The Employer/Sponsor will make PHI available to the member who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524, Access of Individual to PHI.
 - (g) The Employer/Sponsor will make members’ PHI available for amendment, and will on notice amend members’ PHI, in accordance with 45 Code of Federal Regulations § 164.526, Amendment of PHI.
 - (h) The Employer/Sponsor will track disclosures it may make of members’ PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528, Accounting of Disclosures of PHI.

¹ Summary information summarizes the claims history, claims expenses, or types of claims of individuals covered under a group health plan, and from which individual identifiers have been removed.

² Health information that is received, created, maintained or transmitted in electronic form or in any other form or medium by a health plan, insurer or HMO that identifies the individual or can be used to identify the individual and that relates to an individual’s physical or mental health or condition, including information related to an individual’s care or the payment for such care.

Appendix A

- (i) The Employer/Sponsor will make its internal practices, books, and records, relating to its use and disclosure of members' PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- (j) The Employer/Sponsor will, if feasible, return or destroy all member PHI, in whatever form or medium (including in any electronic medium under the Employer's/ Sponsor's custody or control), received from the Plan that the Employer/Sponsor still maintains, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the members' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all members' PHI, the Employer/Sponsor will limit the use or disclosure of any member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation between the Employer/Sponsor and the Plan

- 4. (a) The Employer/Sponsor will ensure the adequate separation between employees and the Plan, supported by reasonable and appropriate security measures.
 - 1) All employees or classes of employees or other workforce members under the control of the Employer/Sponsor may be given access to or may receive members' PHI relating to payment under or health care operations of the Plan, or other matters pertaining to the Plan in the ordinary course of business.
 - 2) The employees, classes of employees or other workforce members identified above will have access to members' PHI only to perform the Plan administration functions that the Employer/Sponsor provides for the Plan.
- (b) The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer/Sponsor, for any use or disclosure or security incident of members' PHI in breach or violation of or noncompliance with these provisions of the Plan Documents. The Employer/Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(e), and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy or security of whose PHI may have been compromised by the breach, violation or noncompliance.

Health Care Terms and Definitions

Refer to these definitions to help you better understand your coverage. Need more help? Additional terms and definitions can be viewed at www.empireblue.com.

Adverse Determination

A communication from Empire's Medical Management that reduces or denies benefits.

Allowed Amount

The maximum Empire will pay for a covered service whether it is In-Network or Out-of-Network. The Allowed Amount is based on an agreement between Empire and the Provider, or if there is no agreement, then on the customary charge or the average market charge in your geographic area for a similar service. You are responsible for paying the entire portion above the Allowed Amount when covered services are Out-of-Network.

Ambulatory Surgery

See "Same-Day Surgery."

Authorized Services

See "Precertified Services."

Balance Billing

Amounts owed after the applicable Deductible and Co-insurance when covered services are Out-of-Network.

Co-payment

The fee you pay for office visits and certain Covered Services when you use In-Network Providers.

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 services. You have individual and family deductible limits. For example, if you have family coverage, if any family member meets the individual Deductible, the plan will pay benefits for that family member. Once the family Deductible is met, your PPO plan will pay benefits for covered services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit – if two or more family members are injured in the same accident and require medical care, the family must meet only one individual Deductible.

Hospital/Facility

For the purpose 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 Blue Cross and/or Blue Shield plan.

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

Appendix A

Hospital/Facility *(continued)*

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

For behavioral 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.

In-Network Benefits

Benefits for Covered Services delivered by In-Network Providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Coinsurance

When you receive certain In-Network services, you and your PPO provider share the cost of covered expenses after you meet the deductible. For example, if your PPO pays 80% of the Allowed Amount, you pay 20%.

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

Itemized Bill

A bill from a 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.

Lifetime Maximum

The maximum amount of benefits your plan will pay for covered expenses over the course of your lifetime.

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; or are preventive in nature, such as annual physical examinations, well-woman care, well-child care and immunizations, and are specified by the Plan as covered,
- In accordance with standards of good medical practice,
- In accordance with the medical and surgical appropriateness requirements established under the Empire Blue Cross Blue Shield's medical policy guidelines,

Appendix A

Medically Necessary *(continued)*

- Not experimental, except as otherwise provided in the SPD or this booklet,
- 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 Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's 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, and Westchester.

Out-of-Network Benefits

Reimbursement for covered services provided by Out-of-Network Providers and suppliers. Out-of-Network Benefits are generally subject to a Deductible, coinsurance and any amount above Empire's allowed amount.

Out-of-Network Coinsurance

All Out-of-Network services you receive, you and your PPO share the cost of covered expenses, after you meet the deductible. For example, if your PPO pays 80% of the Allowed Amount, you pay 20% plus any costs above the Allowed Amount.

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

Outpatient Surgery

See "Same-Day Surgery."

Participating Hospital/Facility

A hospital or facility that:

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

Plan Administrator

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

PPACA

The Patient Protection and Affordable Care Act of 2010 (also commonly referred to as "Affordable Care Act" or "Health Care Reform")

Precertified Services

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by your plan. Failure to precertify may result in a reduction or denial of benefits.

Appendix A

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 certified 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 NYS Education Department or a comparable organization in another state and have 3 years of post-degree supervised experience in psychotherapy and an additional 3 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.

Same-Day Surgery

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

Subrogation

Subrogation obligation requirements are set forth in the Summary Plan Description for the Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL CIO Active and Retiree Members in the School Division effective January 1, 2018.

Treatment Maximums

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

Audio Health Library Topics

Following is a list of some of our most popular health-related audiotape topics that you can listen to free of charge, 24 hours a day, seven days a week, when you call 24/7 NurseLine at 1-877-TALK-2RN (825-5276). See the 360° Health section for more information on the 24/7 NurseLine and instructions on how to listen to the tapes. These are our most requested audiotapes. If you do not see the topic that interests you, just ask one of the NurseLine nurses.

Abdominal Problems

1600 Appendicitis
1451 Constipation
1618 Crohn's Disease
1260 Dehydration
1452 Diarrhea
1605 Diverticulosis and Diverticulitis
1402 Food Poisoning
1608 Gallbladder Disease
2154 Gallbladder Surgery
1612 Gastroesophageal Reflux Disease
1610 Heartburn
1952 Hepatitis
1403 Hernia
1603 Inflammatory Bowel Disease
1611 Irritable Bowel Syndrome
2576 Kidney Stones
1462 Nausea and Vomiting
1609 Rectal Problems
1613 Ulcers
2257 Urinary Incontinence in Women
1291 Urinary Tract Infections

Allergies

1000 Allergies
2770 Drug Allergies
1002 Food Allergies
1007 What About Allergy Shots?

Back and Neck Pain

1450 Low Back Pain
1463 Herniated Disk
2174 Low Back Problems , Surgery for
1457 Neck Pain

Bone, Muscle and Joint Problems

1030 Arthritis
1780 Bunions
2103 Bursitis and Tendon Injury
1781 Calluses and Corns
2104 Carpal Tunnel Syndrome
1038 Fibromyalgia
1039 Gout
1784 Heel Spurs
1031 Juvenile Rheumatoid Arthritis
1033 Lupus

2106 Muscle Cramps and Leg Pain
2259 Osteoarthritis
1032 Osteoporosis
1034 Rheumatoid Arthritis
2169 Rotator Cuff
1456 Sports Injuries
2105 Strains, Sprains, Fractures and Dislocations
2151 Surgery for Carpal Tunnel Syndrome
1461 TMJ Disorder

Cancer

1105 Cancer Pain
1110 Colon Polyps
1113 Colorectal Cancer
1120 Women's Cancer
1124 Lung Cancer

Chest, Respiratory and Circulatory Problems

1981 Asthma in Teens and Adults
1908 Atrial Fibrillation (irregular heartbeats)
1983 Bronchitis
1915 Cardiac Rehabilitation
1903 Causes of Heart Attack
1900 Chest Pain
1976 Chronic Obstructive Pulmonary Disease (COPD)
1400 Colds
1907 Heart Failure
1980 Emphysema
1455 Fever
1904 Heart Attack Prevention
1401 Influenza (Flu)
1648 Laryngitis
1910 Mitral Valve Prolapse
1911 Pacemakers
1986 Pneumonia
1406 Sinusitis
1459 Sore Throat and Strep Throat
1081 Stroke Rehabilitation
1460 Swollen Lymph Nodes
1912 Varicose Veins
1407 Viral and Bacterial Infection

Appendix A

Chronic Conditions

1060 ALS (Lou Gehrig's Disease)
1061 Alzheimer's Disease
1950 Chronic Fatigue Syndrome
2570 Chronic Kidney Disease
1063 Epilepsy
1953 Hepatitis B
1909 High Blood Pressure
1832 High Cholesterol
2623 Iron Deficiency Anemia
1959 Living with HIV Infection
1065 Multiple Sclerosis
1066 Parkinson's Disease
1512 Prediabetes
2550 Thyroid Problems
1508 Type 1 Diabetes
1500 Type 2 Diabetes
1501 Type 2 Diabetes: Living with Complications
1502 Type 2 Diabetes: Living with the Disease
1503 Type 2 Diabetes: Recently Diagnosed

Ear, Nose and Throat

1516 Diabetic Retinopathy
1453 Dizziness and Vertigo
1264 Ear Infections
1640 Earwax
1646 Hearing Loss
1641 Inner Ear Infection (Labrynthitis)
1644 Meniere's Disease
1643 Swimmer's Ear
1650 Tonsillitis

Eye Problems

1700 Eye Problems
2152 Cataract Surgery
1709 Cataracts
1710 Color Blindness
1703 Contact Lens Care
1708 Eye Infections
1705 Eye Injuries
1717 Floaters and Flashes
1712 Glaucoma
1711 Macular Degeneration
1716 Laser Surgery for Nearsightedness
1713 Strabismus
1707 Styes
1702 Vision Tests

First Aid and Emergencies

1750 Animal and Human Bites
1761 Burns
1255 Choking
1762 Cuts
2337 Frostbite
1901 Heart Attack

1759 Heat Exhaustion and Heat Stroke
2256 Hypothermia
2203 Importance of CPR Instructions
1751 Insect and Spider Bites and Stings
1458 Nosebleeds
1763 Poisoning
1764 Puncture Wounds
1766 Removing Splinters
1752 Snake Bites
1067 Stroke
1754 Tick Bites

Headaches and Nervous System Problems

1062 Bell's Palsy
1515 Diabetic Neuropathy
1068 Guillain-Barre Syndrome
1064 Encephalitis
1405 Migraine Headaches
1404 Tension Headaches

Home Health Medicines and Supplies

2000 Bulking Agents and Laxatives
2007 Cold and Allergy Remedies
2003 Cough Preparations
2002 Decongestants
1270 How to Take a Temperature
2001 Pain Relievers
1758 Self-Care Supplies

Infant and Child Health

1250 ADHD
1251 Bed-wetting
2753 Bottle-feeding
1254 Chickenpox
1278 Childhood Rashes
1256 Circumcision
1257 Colic
1258 Croup
1261 Diaper Rash
1080 Dyslexia
2436 Fetal Alcohol Syndrome
1253 Fever, Age 3 and Younger
1267 Fifth Disease
1268 Growth and Development of the Newborn
1269 Hand-Foot-Mouth Disease
1837 Healthy Eating for Children
1272 Impetigo
1274 Measles
1275 Mumps
1280 Pinworms
1259 Reye's Syndrome
1283 Roseola
1284 Rubella (German Measles)
1287 Sudden Infant Death Syndrome (SIDS)
1288 Teething
1247 Temper Tantrums

Appendix A

Infant and Child Health *(continued)*

- 1292 Thrush
- 1289 Thumb-Sucking
- 1290 Toilet Training
- 1293 Urinary Tract Infections in Children

Infectious Diseases

- 1408 Avian Influenza (Bird Flu)
- 1951 Infectious Mononucleosis
- 1956 Tuberculosis
- 1965 West Nile Virus

Living Healthy

- 1279 Immunizations
- 1295 Health Screenings
- 1830 Living a Balanced Lifestyle
- 1831 Guidelines for Eating Well
- 1833 Be Physically Active
- 1834 Healthy Weight
- 1835 Mind-Body Connection
- 1838 Alcohol and Drug Problems
- 1841 Be Tobacco-Free
- 1846 Managing Stress
- 1853 Healthy Snacks
- 1964 Relaxation Skills
- 2204 Accident and Injury Prevention
- 2428 Treatment for Alcohol Use Problems
- 2435 Teen Alcohol and Drug Abuse

Medical Tests and Procedures

- 1506 Home Blood Sugar Monitoring
- 1532 Exercise Electrocardiography
- 1533 Complete Blood Count (CBC)
- 1534 Chest X-ray
- 1535 Chorionic Villus Sampling
- 1536 CT Scan of the Body
- 1537 Electroencephalogram
- 1538 Electrocardiogram
- 1539 Electromyography (EMG)
- 1540 Barium Enema
- 1541 Upper Gastrointestinal (GI) Series
- 1542 Magnetic Resonance Imaging
- 1546 Lung Function Tests
- 1547 Abdominal Ultrasound
- 2155 Cystoscopy
- 2156 Dilatation and Curettage
- 2157 Episiotomy
- 2158 Surgery for Hemorrhoids
- 2159 Hernia Surgery
- 2160 Hip Replacement Surgery
- 2162 Arthroscopy
- 2163 Knee Replacement Surgery

- 2164 Laparoscopy
- 2165 Ear Tubes
- 2171 Tonsillectomy and Adenoidectomy
- 2503 Shared Decisions about Surgery

Men's Health

- 1128 Prostate Cancer
- 1545 Prostate-Specific Antigen Test (PSA Test)
- 2031 Hair Loss
- 2034 Benign Prostatic Hyperplasia (Enlarged Prostate)
- 2036 Testicular Problems
- 2167 TURP for BPH

Mental Health Problems and Mind-Body Wellness

- 1069 Bipolar Disorder
- 1070 Schizophrenia
- 1071 Dementia
- 1230 Domestic Violence
- 1240 Child Maltreatment
- 1845 Stress Management
- 2051 Obsessive-compulsive Disorder
- 2052 Eating Disorders
- 2055 Panic Attacks and Panic Disorder
- 2057 Depression
- 2059 Grief
- 2063 Social Anxiety Disorder
- 2066 Suicide

Partnership with your doctor

- 1201 Patients' Bill of Rights
- 1202 Caregiver Secrets
- 1800 Skills for Making Wise Health Decisions
- 1801 Work in Partnership with your Doctor
- 1802 Finding a Doctor Who Will be a Partner

Senior Health

- 1836 Seniors Staying Active and Fit
- 2004 Medication Problems in Seniors
- 2006 Medications and Older Adults
- 2240 Hospice Care
- 2245 Care at the End of Life
- 2251 Nutrition for Older Adults
- 2261 Skin and Nail Problems in Seniors

Appendix A

Skin Problems

- 1129 Skin Cancer
- 1273 Lice and Scabies
- 1755 Blisters
- 1785 Ingrown Toenails
- 2330 Acne
- 2332 Boils
- 2333 Cold Sores
- 2334 Dandruff
- 2336 Atopic Dermatitis
- 2338 Hives
- 2343 Rashes
- 2344 Psoriasis
- 2346 Fungal Infections
- 2349 Shingles
- 2352 Sunburn
- 2353 Warts

Sleeping Disorders

- 2400 Sleep Problems
- 2403 Sleep Apnea
- 2406 Snoring

Women's Health

- 1107 Breast Health
- 1111 Ovarian Cancer
- 1112 Polycystic Ovary Syndrome
- 1211 Multiple Pregnancy: Twins or More
- 1504 Gestational Diabetes
- 1531 Breast Biopsy
- 1544 Pelvic Exam and Pap Test
- 1548 Ultrasound for Normal Pregnancy
- 2312 Pelvic Inflammatory Disease
- 2426 Pregnancy, Precautions During
- 2640 Bacterial Vaginosis
- 2643 Yeast Infections
- 2650 Menopause
- 2651 Hormone Therapy
- 2670 Missed or Irregular Periods
- 2672 Endometriosis
- 2673 Uterine Fibroids
- 2674 Hysterectomy
- 2675 Bleeding Between Periods
- 2677 Functional Ovarian Cysts
- 2678 Menstrual Cramps
- 2679 Dysfunctional Uterine Bleeding

- 2680 Toxic Shock Syndrome
- 2700 How to Make a Healthy Baby
- 2701 Home Pregnancy Test
- 2704 Danger signs during pregnancy
- 2705 Normal Pregnancy
- 2706 Symptoms and Stages of Labor
- 2708 Diet During Pregnancy
- 2709 Exercise During Pregnancy
- 2710 Rubella and Pregnancy
- 2714 Amniocentesis
- 2717 Miscarriage
- 2719 Stretch Marks
- 2720 Cesarean Section
- 2723 Pelvic Organ Prolapse
- 2724 Premenstrual Syndrome
- 2725 Pregnancy, Symptoms and Stages of
- 2750 Postpartum Depression
- 2751 Breast Feeding
- 2752 Complications after delivery
- 2754 Labor, Delivery, and Postpartum Period
- 2755 Mastitis While Breast-Feeding
- 2756 Rh Sensitization During Pregnancy
- 2757 Weaning

*Additional topics, that are not listed, are also available.

APPENDIX B

LIST OF THE PLAN'S FEE SCHEDULE FOR DENTAL BENEFITS

NOTE: All dental services over \$500.00 must be pre-approved by Sele-Dent. Please call or visit the Fund Office or visit the Plan's website: <http://www.local94.com> for a copy of this Fee Schedule.

D0100 – D0999 I. Diagnostic

Plan's Fee Schedule

D0120	Periodic oral evaluation (1 per calendar year)	\$ 15.00
D0140	Limited oral evaluation – problem focused	\$ 15.00
D0150	Comprehensive oral evaluation – new or established patient	\$ 15.00
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$ 15.00
D0120	Intraoral – full mouth series (including bitewings) x-rays once every 5 calendar years over the age of 12	\$ 32.00
D0220	Intraoral – periapical first film	\$ 5.00
D0230	Intraoral – periapical each additional film	\$ 5.00
D0270	Bitewing – single film	\$ 5.00
D0272	Bitewing – two films	\$ 10.00
D0274	Bitewing – four films	\$ 20.00
D0330	Panoramic film (once per calendar year)	\$ 27.00

D1000 – D1999 II. Preventive

D1110	Prophylaxis – Adult (13 years of age and older - 2 per calendar year)	\$ 23.00
D1120	Prophylaxis – Child (Under 13 years of age – 2 per calendar year)	\$ 14.00
D1203	Topical application of fluoride – Child (up to 16 years of age)	\$ 17.00
D1351	Sealant – per tooth (any tooth up to the age of 16)	\$ 13.00
D1510	Space maintainer – fixed – unilateral (every 3 years)	\$ 59.00
D1515	Space maintainer – fixed – bilateral (every 3 years)	\$ 89.00
D1520	Space maintainer – removable – unilateral (every 3 years)	\$ 59.00
D1525	Space maintainer – removable – bilateral (every 3 years)	\$ 89.00
D1550	Re-cementation of space maintainer	\$ 14.00

D2000 – D2999 III. Restorative

D2140	Amalgam – one surface, primary or permanent	\$ 21.00
D2150	Amalgam – two surfaces, primary or permanent	\$ 34.00
D2160	Amalgam – three surfaces, primary or permanent	\$ 48.00
D2161	Amalgam – four or more surfaces, primary or permanent	\$ 48.00
D2330	Resin-based composite – one surface, anterior	\$ 27.00
D2331	Resin-based composite – two surfaces, anterior	\$ 48.00
D2332	Resin-based composite –three surfaces, anterior	\$ 48.00
D2335	Resin-based composite –four or more surfaces or involving incisal angle - anterior	\$ 48.00
D2391	Resin-based composite – one surface, posterior (once every 6 months)	\$ 27.00
D2392	Resin-based composite – two surfaces, posterior (once every 6 months)	\$ 48.00
D2393	Resin-based composite – three surfaces, posterior (once every 6 months)	\$ 48.00
D2394	Resin-based composite – four or more surfaces or involving incisal angle – posterior	\$ 48.00
D2510	Inlay – metallic – one surface (once every 6 months)	\$ 89.00

Appendix B

Plan's Fee Schedule

D2520	Inlay – metallic – two surfaces (once every 6 months)	\$ 89.00
D2530	Inlay – metallic – three or more surfaces (once every 6 months)	\$111.00
D2542	Onlay – metallic – two surfaces (once every 6 months)	\$ 89.00
D2543	Onlay – metallic – three surfaces (once every 6 months)	\$111.00
D2544	Onlay – metallic – four or more surfaces (once every 6 months)	\$111.00
D2610	Inlay – porcelain/ceramic – one surface (once every 6 months)	\$ 89.00
D2620	Inlay – porcelain/ceramic – two surfaces (once every 6 months)	\$ 89.00
D2630	Inlay – porcelain/ceramic – three surfaces (once every 6 months)	\$111.00
D2642	Onlay – porcelain/ceramic – two surfaces (once every 6 months)	\$ 89.00
D2643	Onlay – porcelain/ceramic – three surfaces (once every 6 months)	\$111.00
D2644	Onlay – porcelain/ceramic – four or more surfaces (once every 6 months)	\$111.00
D2710	Crown – resin (indirect – every 3 years)	\$172.00
D2720	Crown – resin with high noble metal (every 3 years)	\$273.00
D2721	Crown – resin with predominantly base metal (every 3 years)	\$273.00
D2722	Crown – resin with noble metal (every 3 years)	\$273.00
D2750	Crown – porcelain fused to high noble metal (every 3 years)	\$287.00
D2751	Crown – porcelain fused to predominantly based metal (every 3 years)	\$287.00
D2752	Crown – porcelain fused to noble metal (every 3 years)	\$287.00
D2790	Crown – full cast high metal (every 3 years)	\$261.00
D2791	Crown – full cast predominantly base metal (every 3 years)	\$261.00
D2792	Crown – full cast noble metal (every 3 years)	\$261.00
D2810	Crown – $\frac{3}{4}$ cast metallic (every 3 years)	\$167.00
D2910	Recement inlay (every 6 months)	\$ 14.00
D2920	Recement crown (every 6 months)	\$ 14.00
D2930	Prefabricated stainless steel crown – primary tooth (up to age 16 – every 3 years)	\$ 59.00
D2931	Prefabricated stainless steel crown – permanent tooth (up to age 16 - every 3 years)	\$ 73.00
D2932	Prefabricated resin crown (up to age 16 – every 3 years)	\$ 48.00
D2933	Prefabricated stainless steel crown with resin window (up to age 16 – every 3 years)	\$ 48.00
D2940	Sedative filling (once per tooth every 6 months)	\$ 14.00
D2950	Core buildup, including any pins (every 3 years)	\$ 61.00
D2951	Pin retention – per tooth, in addition to restoration	\$ 14.00
D2952	Cast post and core in addition to crown (every 3 years)	\$ 89.00
D2954	Prefabricated post and core in addition to crown (every 3 years)	\$ 89.00
D2980	Crown repair, by report	\$ 28.00

D3000 – D3999 IV. Endodontic

D3110	Pulp cap – direct (excluding final restoration)	\$ 8.00
D3120	Pulp cap – indirect (excluding final restoration)	\$ 8.00
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	\$ 37.00
D3310	Anterior (excluding final restoration – every 3 years)	\$160.00
D3320	Bicuspid (excluding final restoration – every 3 years)	\$213.00
D3330	Molar (excluding final restoration – every 3 years)	\$273.00
D3346	Retreat of anterior teeth (every 3 years)	\$210.00
D3347	Retreat of bicuspid teeth (every 3 years)	\$288.00
D3348	Retreat of molar teeth (every 3 years)	\$373.00
D3410	Apicoectomy/periradicular surgery – anterior (every 3 years)	\$147.00
D3421	Apicoectomy/periradicular surgery – bicuspid (first root – every 3 years)	\$147.00
D3425	Apicoectomy/periradicular surgery – molar (first root – every 3 years)	\$147.00
D3426	Apicoectomy/periradicular surgery (each additional root – every 3 years)	\$221.00

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D4000 – D4999 V. Periodontic

Plan's Fee Schedule

D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bound teeth spaces per quadrant	\$187.00 / Sp. \$320.00
D4211	Gingivectomy or gingivoplasty (4 teeth per year)	\$ 40.00 / Sp. \$ 80.00
D4249	Clinical crown lengthening – hard tissue	\$125.00
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant (4 quads per year)	\$187.00 / Sp. \$320.00
D4263	Bone replacement graft – first site quadrant	\$152.00
D4273	Subepithelial connective tissue graft procedures periodontal scaling and root planning – four or more contiguous teeth or bounded	\$103.00
D4341	Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant (general 4 quads/specialist 5 quads)	\$ 40.00 / Sp. \$ 80.00
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$ 55.00

D5000 – D5899 VI. Prosthodontic (removable)

D5110	Complete denture – maxillary (every 3 years)	\$367.00
D5120	Complete denture – mandibular (every 3 years)	\$367.00
D5130	Immediate denture – maxillary (every 3 years)	\$367.00
D5140	Immediate denture – mandibular (every 3 years)	\$367.00
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth – every 3 years)	\$267.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth – every 3 years)	\$267.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth – every 3 years)	\$400.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth – every 3 years)	\$400.00
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth – every 3 years)	\$103.00
D5410	Adjust complete denture – maxillary (every 6 months)	\$ 73.00
D5411	Adjust complete denture – mandibular (every 6 months)	\$ 73.00
D5421	Adjust partial denture – maxillary (every 6 months)	\$ 73.00
D5422	Adjust partial denture – mandibular (every 6 months)	\$ 73.00
D5510	Repair broken complete denture base (every 6 months)	\$ 66.00
D5520	Replace missing or broken teeth – complete denture (each tooth – every 6 months)	\$ 48.00
D5610	Repair resin denture base (every 6 months)	\$ 40.00
D5620	Repair cast framework (every 6 months)	\$ 22.00
D5630	Repair or replace broken clasp (every 6 months)	\$ 15.00
D5640	Repair broken teeth (every 6 months)	\$ 28.00 per tooth
D5650	Add tooth to existing partial denture (every 6 months)	\$ 48.00
D5660	Add clasp to existing partial denture (every 6 months)	\$ 73.00
D5710	Rebase complete maxillary denture (every 6 months)	\$114.00
D5711	Rebase complete mandibular denture (every 6 months)	\$114.00
D5720	Rebase maxillary partial denture (every 6 months)	\$114.00
D5721	Rebase mandibular partial denture (every 6 months)	\$114.00
D5730	Reline complete maxillary denture (chairside – every 6 months)	\$ 67.00

Appendix B

Plan's Fee Schedule

D5731	Reline complete mandibular denture (chairside – every 6 months)	\$ 67.00
D5740	Reline maxillary partial denture (chairside – every 6 months)	\$ 67.00
D5741	Reline mandibular partial denture (chairside – every 6 months)	\$ 67.00
D5750	Reline complete maxillary denture (laboratory – every 6 months)	\$101.00
D5751	Reline complete mandibular denture (laboratory – every 6 months)	\$101.00
D5760	Reline maxillary partial denture (laboratory – every 6 months)	\$101.00
D5761	Reline mandibular partial denture (laboratory – every 6 months)	\$101.00

D6000 – D6199 VII. Implant Services

Dental implants are covered procedures when they are pre-approved by Sele-Dent. Eligible participants will be responsible for applicable co-pays if visiting a provider in the Local 94 network**. However, if you visit a Sele-Dent, Inc. or an out of network dentist for dental implants, you will be responsible for fees in excess of the Plan's fee schedule. *

	<u>*Plan's Fee Schedule</u>	<u>**Patient Co-Payment</u>
Effective 1/1/17		
D6010	Surgical placement of implant body; endosteal implant	\$600.00
D6056 or D6057	Prefabricated abutment	\$239.00
D6059 or D6060	Abutment supported porcelain fused to metal crown (predominantly base metal or noble metal)	\$437.00

D6200 – D6999 IX. Prosthodontic (fixed)

Plan's Fee Schedule

D6210	Pontic – cast high noble metal (every 3 years)	\$187.00
D6211	Pontic – cast predominantly base metal (every 3 years)	\$187.00
D6212	Pontic – cast noble metal (every 3 years)	\$187.00
D6240	Pontic – porcelain fused to high noble metal (every 3 years)	\$187.00
D6241	Pontic – porcelain fused to predominantly base metal (every 3 years)	\$187.00
D6250	Pontic – resin with high noble metal (every 3 years)	\$187.00
D6252	Pontic – resin with noble metal (every 3 years)	\$187.00
D6530	Inlays used as abutments, three or more surfaces (every 3 years)	\$134.00
D6720	Crown – resin with high noble metal (every 3 years)	\$273.00
D6721	Crown – resin with predominantly base metal (every 3 years)	\$273.00
D6722	Crown – resin with noble metal (every 3 years)	\$273.00
D6751	Crown – porcelain fused to predominantly base metal (every 3 years)	\$287.00
D6752	Crown – porcelain fused to noble metal (every 3 years)	\$287.00
D6780	Crown – ¾ cast noble metal (every 3 years)	\$167.00
D6790	Crown – full cast high noble metal (every 3 years)	\$261.00
D6791	Crown – full cast predominantly base metal (every 3 years)	\$261.00
D6930	Recement fixed partial denture (every 6 months)	\$ 37.00
D6970	Cast post and core in addition to fixed partial denture retainer (every 6 months)	\$ 89.00

Appendix B

Plan's Fee Schedule

D7000 – D7999 X. Oral and Maxillofacial Surgery

D7110	Routine extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$ 34.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, suture	\$ 61.00
D7220	Removal of impacted tooth – soft tissue	\$ 67.00
D7230	Removal of impacted tooth – partial bony	\$120.00
D7240	Removal of impacted tooth – completely bony	\$167.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$167.00
D7250	Surgical removal of residual tooth roots	\$ 73.00
D7260	Oroantral fistula closure	\$134.00
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$101.00
D7286	Biopsy of oral tissue – soft (all others)	\$ 54.00
D7310	Alveoplasty in conjunction with extractions – per quadrant	\$ 10.00
D7320	Alveoplasty not in conjunction with extractions – per quadrant	\$ 94.00
D7510	Incision and drainage of abscess – intraoral soft tissue	\$ 34.00
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	\$ 73.00

D8000 – D8999 XI. Orthodontia

Note: All orthodontia services must be pre-approved by Sele-Dent. Orthodontia benefits are available for dependent children under age 19 only.

D8220	Fixed appliance therapy (once per lifetime dependents 19 years and under)	\$ 491.00
D8670	Periodic orthodontic treatment visit (\$74.00 per month for 20 months)	\$1,480.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) as part of the contract (18 months \$61.00 – every 6 months)	\$ 183.00

Maximum Paid \$2,154.00

D9000 – D9999 XII. Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain – minor procedure (1 per year)	\$ 14.00
D9220	Deep sedation/general anesthesia – first 30 minutes (oral surgeon)	\$ 54.00
D9221	Deep sedation/general anesthesia – each additional 15 minutes (oral surgeon)	\$ 22.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment (1 per year)	\$ 40.00
D9951	Occlusal adjustment – limited (every 6 months)	\$ 14.00
D9952	Occlusal adjustment – complete (every 6 months)	\$ 14.00

NOTE: All implants and orthodontia services must be pre-approved by Sele-Dent. In addition, all dental services over \$500.00 must be approved by Sele-Dent. Prior approval is necessary if your dentist is a participating dentist in Local 94's Network, Sele-Dent's PPO Network or an out of network provider. An approved treatment plan submitted by a dental provider can be used by that provider and only for the approved dental care within one (1) year of the date of the approval. Any change to your approved treatment plan will be treated as a new treatment plan for which you will be required to submit for review and approval.

APPENDIX C

Partial List of Sele-Dent's Schedule of Co-payments for Dental Benefits
Utilizing Sele-dent's PPO Network

Please call or visit the Fund Office or visit the Plan's website: <http://www.local94.com> for a copy of this Fee Schedule.

	<u>PATIENT CO-PAYMENT</u>
<u>DIAGNOSTIC & PREVENTIVE SERVICES</u>	
Detail/extensive oral evaluation	\$ 15.00
Panoramic x-ray	\$ 10.00
Prophylaxis – child	\$ 5.00
Exam and panoramic x-ray once per Calendar Year	
Prophylaxis two (2) per Calendar Year	
<u>SPACE MAINTAINER (Up to age 19)</u>	
Space maintainer (fixed unilateral)	\$ 15.00
Space maintainer (fixed-bilateral)	\$ 10.00
Space maintainer (removable-unilateral)	\$ 40.00
Space maintainer (removable-bilateral)	\$ 5.00
Re-cementation of space maintainer	\$ 5.00
Space maintainer replacement once every three (3) Calendar Years	
<u>RESTORATIVE DENTISTRY</u>	
Resin composite- three (3) surfaces anterior	\$ 30.00
Resin composite-four (4) or more anterior	\$ 30.00
Resin composite one (1) surface posterior	\$ 10.00
Resin composite two (2) surfaces posterior	\$ 10.00
Resin composite three (3) surfaces posterior	\$ 40.00
Resin composite four (4) or more posterior	\$ 50.00
<u>Inlays/Onlays</u>	
Inlay –metallic- one (1) surface	\$ 45.00
Inlay – metallic two (2) surfaces	\$ 70.00
Inlay – metallic three (3) surfaces or more	\$ 90.00
Onlay – metallic – two (2) surfaces	\$ 15.00
Onlay – metallic –three (3) surfaces	\$ 45.00
Onlay – metallic- four (4) or more surfaces	\$ 95.00
Inlay – porcelain /ceramic - two (2) surfaces	\$ 70.00
Inlay – porcelain/ceramic -three (3) surfaces	\$130.00
Onlay – porcelain/ceramic –two (2) surfaces	\$ 15.00
Onlay- porcelain/ceramic- three (3) surfaces	\$ 45.00
Onlay- porcelain/ceramic-four (4) surfaces	\$ 95.00
Replacement Inlays/Onlay once every six (6) consecutive months	
<u>PROSTHETICS CROWNS</u>	
Crown-resin (indirect)	\$ 50.00
Crown–porcelain fused high noble	\$ 40.00
Crown-porcelain fused metal base	\$ 40.00
Crown-porcelain fused to noble metal	\$ 40.00
Crown-full cast high noble metal	\$ 15.00
Crown-full cast predominantly base metal	\$ 15.00
Crown-full cast noble metal	\$ 15.00
Crown gold ¾ cast	\$ 50.00

Appendix C

PATIENT CO-PAYMENT

Replacement crown once every three (3) Calendar Years

Prefabricated stainless steel crown	\$ 10.00
Pin retention per tooth in addition	\$ 15.00

Prefabricated crowns up to age 16 once every three (3) Calendar Years

ROOT CANAL THERAPY

Pulp Cap (direct)	\$ 5.00
Pulp Cap (indirect)	\$ 5.00
Bicuspid (root-canal two (2) canals)	\$ 5.00
Molar (root-canal three (3) canals)	\$ 25.00
Apicoectomy first root (once every three (3) Calendar Years)	\$ 55.00

Root Canal treatment once every three (3) Calendar Years

PERIODONTICS

Gingivectomy four (4) teeth per Calendar Year (4211)	\$ 40.00
Osseous surgery four (4) quads per Calendar Year	\$140.00 Sp. \$5.00
Connective tissue graft	\$145.00

PROSTHETICS (REMOVABLE)

Complete denture –maxillary	\$ 20.00
Complete denture – mandibular	\$ 20.00
Immediate denture – maxillary	\$ 45.00
Immediate denture – mandibular	\$ 45.00
Maxillary partial denture resin base	\$ 95.00
Mandibular partial denture resin base	\$ 95.00
Removable unilateral partial denture	\$ 60.00

Replacement Dentures once every three (3) Calendar Years

Repair clasp framework	\$ 15.00
Repair or replace broken clasp	\$ 5.00
Rebase complete maxillary denture	\$ 85.00
Rebase complete mandibular denture	\$ 85.00
Rebase complete maxillary partial denture	\$ 50.00
Rebase complete mandibular partial denture	\$ 50.00
Reline complete maxillary denture (chairside)	\$ 20.00
Reline complete mandibular denture (chairside)	\$ 20.00

Denture adjustment/repair every six (6) consecutive months

PROSTHETICS - FIXED BRIDGES

Pontic-cast high noble metal	\$ 15.00
Pontic-cast predominantly base metal	\$ 80.00
Pontic-porcelain fused to high noble metal	\$ 80.00
Pontic-resin with high noble metal	\$ 80.00
Pontic- resin with noble metal	\$ 80.00
Inlays abutments, three (3) or more surfaces	\$ 65.00
Crown- porcelain fused to metal base	\$ 40.00
Crown- porcelain fused to noble metal	\$ 40.00
Crown- ¾ cast noble metal	\$ 35.00
Crown-full cast high noble metal	\$ 10.00
Crown-full cast predominantly base metal	\$ 10.00

Replacement on fixed bridges once every three (3) Calendar Years

Appendix C

PATIENT CO-PAYMENT

ORAL SURGERY

Surgical removal of erupted tooth	\$ 40.00
Removal of impacted tooth- soft tissue	\$ 45.00
Removal of impacted tooth – partial bony	\$ 40.00
Removal of impacted tooth – complete bony	\$ 80.00
Removal of impacted tooth w/complications	\$ 80.00
Oroantral fistula closure.	\$ 20.00
Surgical exposure of impacted tooth	\$ 35.00
Alveoloplasty in conjunction w/extraction (per quad per Calendar Year)	\$ 80.00
Alveoloplasty not-in conjunction w/extraction (per quad per Calendar Year)	\$ 40.00
Incision and Drainage.	\$ 30.00

ANESTHESIA

Palliative treatment (once per Calendar Year)	\$ 5.00
Deep sedation/general anesthesia (30 minutes per treatment)	\$ 20.00
Deep sedation/general anesthesia (add 15 minutes per treatment)	\$ 55.00
Consultation (once per Calendar Year)	\$ 35.00
Occlusal adjustment limited (once every six (6) consecutive months)	\$ 45.00
Occlusal adjustment complete (once every six (6) consecutive months)	\$120.00

NOTE: All implants and orthodontia services must be pre-approved by Sele-Dent. In addition, all dental services over \$500.00 must be approved by Sele-Dent. Prior approval is necessary even if your dentist is a participating dentist in Local 94's Network or Sele-Dent's PPO Network. An approved treatment plan submitted by a dental provider can be used by that provider and only for the approved dental care within one (1) year of the date of the approval. Any change to your approved treatment plan will be treated as a new treatment plan for which you will be required to submit for review and approval.

If you visit a Sele-Dent or a non-participating dentist for dental implants or orthodontics, you will be responsible for fees in excess of the Schedule of Benefits for these services.

APPENDIX D

The Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No. 94-94A-94B, AFL-CIO

Notice of Privacy Practices

Effective as of September 23, 2013

Section 1: Purpose of This Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice Is Required By Law

During the course of providing you with health coverage, the Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No. 94-94A-94B, AFL-CIO (“Fund”) will have access to health information about you that has been deemed to be protected (referred to in this Notice as “Protected Health Information” or “PHI”) pursuant to the privacy rules issued under the Health Insurance Portability and Accountability Act of 1996 (commonly known as “HIPAA”), as amended by the Health Information Technology For Economic and Clinical Health Act (“HITECH”). As a result, the Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- How the Fund uses and discloses your PHI,
- Your privacy rights with respect to your PHI;
- The Fund’s duties with respect to your PHI;
- Your right to file a complaint with the Fund and with the Office of Civil Rights of the United States Department of Health and Human Services, and
- The person or office to contact for further information about the Fund’s privacy practices.

Accordingly, this Notice has been drafted pursuant to the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 C.F.R. Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule, as amended by HITECH.

The Fund reserves the right to change the terms of this Notice and to make new provisions regarding your PHI that it maintains, as permitted or required by law. If the Fund makes a material change to this Notice, it will provide you with a copy of the revised Notice of Privacy Practices.

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Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

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

How the Fund May Use and Disclose Your Protected Health Information

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

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

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

For Treatment, Payment and Health Care Operations

Treatment

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

Payment

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

Health Care Operations

The Fund may use or disclose your PHI as part of its general administrative or business functions in order for it to function as a health plan. These functions include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, disease management, activities relating to the creation and renewal of insurance and benefit administration contracts, legal services, auditing services, and general administrative activities,

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including data and information systems management. For example, the Fund may use information from your claims to refer you to case management, determine benefit costs, or for auditing the accuracy of claims processing functions.

Disclosure To Third Parties

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

Reminders

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

Treatment Alternatives

The Fund may use your PHI to inform you about treatment alternatives.

Health-Related Benefits and Services

The Fund may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.

Disclosure to the Plan Sponsor

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

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

When the Disclosure of Your PHI Requires Your Written Authorization

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

- Using or disclosing psychotherapy notes about you from your psychotherapist.
- Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund is not likely to have access to or maintain these types of notes.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Fund receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.

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- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.
- Using and disclosing your PHI for any use or disclosure not described within this Notice.
At any time, you may revoke your authorization in writing except where the Fund has taken action in reliance on your authorization.

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

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

- (1) When required by law.
- (2) When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- (3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under law when the parents or other representatives may not be given access to the minor's PHI.
- (4) The Fund may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations and audits; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); or for the government to monitor the health care system, government programs and compliance with civil rights laws.
- (5) The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request or other lawful process by someone involved in such legal dispute, provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Fund that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- (6) When required for law enforcement health purposes, including the reporting of certain types of wounds. Also when required for law enforcement emergency purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Fund in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement emergency purposes include identifying or locating a suspect, fugitive, material witness or missing person, and disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
- (7) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

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- (8) The Fund may use or disclose PHI for research, subject to certain conditions and limitations.
- (9) When consistent with applicable law and standards of ethical conduct if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- (10) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- (11) The Fund is permitted to disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your PHI, or the research involves a limited data set which includes no unique identifiers (information such as name, address, social security number, etc., that can identify you).
- (12) When the appropriate conditions apply, the Fund may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. The Fund may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.
- (13) If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Fund may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.
- (14) If you are an organ donor, the Fund may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Any other Fund uses and disclosures not described in Section 2 of this Notice will be made only if you provide the Fund with written authorization, subject to your right to revoke your authorization. If you provide us with written authorization to use or disclose your PHI for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time. If you revoke your authorization, the Fund will no longer use or disclose your PHI for the reasons covered by your written authorization. However, the Fund is unable to take back any disclosures that the Fund has already made with your authorization, and the Fund is required to retain records of the care that the Fund provided to you.

Disclosures to Others Involved in Your Health Care

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

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

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

Section 3: Your Individual Privacy Rights

Breach Notification

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

Uses and Disclosures Requiring Your Written Authorization

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

Personal Representatives

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

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

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

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

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

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

Make such requests to:

Privacy Officer
Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No.
94-94A-94B, AFL-CIO
331-337 West 44th Street
New York, New York, 10036
Phone number: (212) 541-9880

Right to Inspect and Copy PHI

You have the right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, case management and other decisions about you – for as long as the Fund maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Fund will honor that request to the extent possible. You

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also may request a summary of your PHI. Requests for access to your PHI must be made in writing. Requested information will be provided within 30 days of receipt of your request. A single 30-day extension is allowed if the Fund provides you with a written statement of the reasons for the delay and the expected date by which the Fund will provide the information.

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

You may be charged a reasonable, cost-based fee for copying the PHI, or preparing a summary of your PHI. The Fund will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Requests for access to PHI should be made to the following officer:

Privacy Officer
Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No.
94-94A-94B, AFL-CIO
331-337 West 44th Street
New York, New York, 10036
Phone number: (212) 541-9880

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

Right to Amend PHI

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

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

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

Your request to amend your PHI must be made in writing to the following officer.

Privacy Officer
Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union
No. 94-94A-94B, AFL-CIO
331-337 West 44th Street
New York, New York, 10036
Phone number: (212) 541-9880

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

Right to Receive an Accounting of PHI Disclosures

The Fund will also provide you with an accounting of disclosures by the Fund of your PHI during the six (6) years prior to the date of your written request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; (4) based on your written authorization; (5) to friends or family in your presence or because of an emergency; (6) for national security purposes;

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and (7) incidental to otherwise permissible disclosures. Any request for an accounting must be submitted in writing. An accounting will be provided within 60 days of receipt of your request. Your first request for an accounting in a 12-month period will be responded to without charge. You may be charged a reasonable, cost-based fee for each additional request for an accounting within such 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Submission of Requests

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

Right to Receive Paper Copy of This Notice Upon Request

You have the right to receive a paper copy of this Notice, contact the following officer:

Privacy Officer
Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union
No. 94-94A-94B, AFL-CIO
331-337 West 44th Street
New York, New York, 10036
Phone number: (212) 541-9880

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

