# NORTHEAST CARPENTERS HEALTH FUND

# SUMMARY PLAN DESCRIPTION FOR ACTIVE PARTICIPANTS IN THE LONG ISLAND, WESTCHESTER, HUDSON VALLEY AND ROCKLAND AREAS IN NEW YORK (HOME LOCALS 279 and 290)

**REVISED**

**July 1, 2017**

# NORTHEAST CARPENTERS HEALTH FUND

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Dear Participant:

We are pleased to provide you with this updated and revised Summary Plan Description ("SPD" or "Plan") for the Northeast Carpenters Health Fund ("Fund") for active Participants and their eligible Dependents in the Long Island, Westchester, Hudson Valley and the Rockland areas of New York. This SPD describes the benefits available to you under the Northeast Carpenters Health Fund as of July 1, 2017. You should refer to this booklet whenever you need information about your plan of benefits. The Board of Trustees reserves the right, in its sole discretion, to revise this SPD at any time. You will be notified of any material changes to this SPD as required by law. This SPD is the Fund's Plan document.

This document is both the Plan Document and the Summary Plan Description of the Northeast Carpenters Health Fund for active Participants working in Long Island, Westchester, Hudson Valley and Rockland, for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The terms contained herein constitute the terms of the Plan.

It is important that you understand how the Plan works and we encourage you to read this SPD carefully. You should also share it with your Dependents so that they are aware of the benefits to which they may be entitled. Every effort has been made to provide you with a clear understanding and description of the benefits. Certain terms used in this SPD have specific meanings with respect to your benefits. These words are capitalized and are defined in the definition section. The words "you" and "your" refer to the Participant unless the context clearly provides otherwise.

The Board of Trustees has the power to interpret, apply, construe and amend the provisions of the SPD and make factual determinations regarding its construction, interpretation and application. Any decisions made by the Board of Trustees, in good faith, are binding upon Contributing Employers, Participants, Dependents, and all other persons who may be involved with the Fund. It is extremely important that you keep the Fund Office informed of any changes in your address, marital status or desired changes to your Beneficiary designation. This is your obligation and your benefits can be delayed if you fail to do so.

Please remember that no one other than the Fund Office Staff can verify your eligibility for benefits and the benefits to which you are entitled. You should not rely on statements regarding benefits made by your Contributing Employer, Union agent, shop steward, supervisor or other Participants. If you have trouble understanding any part of this material, or have any questions about your benefits, contact the Fund office at 270 Motor Parkway, Suite 2, Hauppauge, New York 11788, 1-877-372-3236, Monday through Friday 8:00 AM through 4:30 PM.

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# Definitions

Certain words have specific meanings with respect to the Fund. These words are capitalized throughout the SPD.

**Contributing Employer or Employer** is a company that has signed a collective bargaining agreement with the Union or entered into a written participation agreement with the Board of Trustees that requires contributions to be made to the Fund for work performed by employees that are in Covered Employment.

**Co-Insurance** means the amount that you are required to pay out-of-pocket for Out-Of-Network Benefits.

**Co-payment** means the fee you pay for office visits and certain covered services when you use In-Network Providers. The Plan then generally pays 100% of remaining covered expenses.

**Covered Employment** means work in a job classification for which your Contributing Employer is required to make contributions to the Fund on your behalf. If you work in employment covered by another welfare fund that has a reciprocal agreement with this Fund, and your contributions to the other fund are transferred to this Fund, the hours you work for which contributions are made to the other fund will be counted as hours of Covered Employment under this Fund.

**Deductible** means the amount that you must pay out-of-pocket each year before benefits become payable on your behalf under the Plan.

**Dependent** means a person who meets the requirements on page 17 and as a result, is eligible for benefits described in the Plan.

**Doctor or Dentist** means a licensed and qualified physician (M.D., D.O., D.C., or D.P.M.) or dentist, a licensed and qualified psychologist, or a licensed midwife, operating within the scope of his or her license or practice.

**"Experimental" or "investigative"** means treatment that, for the particular diagnosis or treatment of the covered person's condition, is not of proven benefit or is 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. Any or all of the following criteria may be required to 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.

**Half Year** means the six-consecutive-month period that starts each January 1st and July 1st.

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

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies;
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times;
- A fully-staffed operating room suitable for major surgery 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; and
- 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 Empire BlueCross BlueShield or another BlueCross and/or BlueShield Plan.

For physical therapy purposes, the definition of a "Hospital" may include a rehabilitation facility either approved by Empire BlueCross BlueShield or participating with Empire BlueCross BlueShield or another BlueCross and/or BlueShield Plan other than specified above.

For kidney dialysis treatment, any 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 BlueCross BlueShield or another BlueCross and/or BlueShield Plan. In other states, the facility must participate with another BlueCross and/or BlueShield Plan and be certified by the state using criteria similar to New York's. Out-Of-Network Benefits will be paid only for non-participating Facilities that have an appropriate operating certificate.

For behavioral health care purposes, the definition of "Hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire BlueCross BlueShield to provide mental and behavioral health care services.

For certain specified benefits, the definition of a "Hospital" or "Facility" may include a hospital, hospital department or facility that has a special agreement with Empire BlueCross BlueShield.

The following facilities are not recognized as Hospitals or Facilities: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care, unless covered under the Fund's mental health or substance abuse treatment coverage.

**In-Network Benefits** means benefits for covered services delivered by In-Network Providers and suppliers. Services provided must fall within the scope of the In-Network Provider's individual professional licenses.

**In-Network Provider/Supplier:** A Participating Hospital/Facility, Doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is in Empire BlueCross BlueShield's network;
- Is in the PPO network of another BlueCross and/or BlueShield Plan; or
- Has a negotiated rate arrangement with another BlueCross and/or BlueShield Plan that does not have a PPO Network.

For non-medical services, an In-Network Provider/Supplier is a provider, supplier or Facility that has entered into an agreement with the Fund to provide services or supplies at a negotiated rate.

**Medically Necessary:** Services, supplies or equipment provided by a Hospital or other provider of health services that are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury;
- In accordance with standards of good medical practice;
- Not solely for the convenience of the patient, the family or the provider,
- Not primarily custodial, and
- The most appropriate level of service that can be safely provided to the patient.

The fact that an In-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 BlueCross BlueShield or another BlueCross and/or BlueShield Plan to provide services to persons covered under the Empire BlueCross BlueShield EPO 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.

**Out-of-Network Benefits** means benefits for covered services delivered by Out-of-Network Providers and Suppliers.

**Out-of-Network Providers/Suppliers:** A Non-Participating Hospital/Facility, Doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is not in Empire BlueCross BlueShield's network; or
- Is not in the PPO network of another BlueCross and/or BlueShield Plan;

**Outpatient Surgery or Ambulatory Surgery** means surgery that does not require an overnight stay in a Hospital.

**Participant** means a person who works in Covered Employment for a Contributing Employer who meets the requirements for participation in the Plan as described on pages 12-13.

**Participating Hospital/Facility** means a Hospital or Facility that is in Empire BlueCross BlueShield's network or is in the PPO network of another BlueCross and/or BlueShield Plan.

**Pre-certified Services:** Services that must be coordinated and approved by Empire BlueCross BlueShield's Medical Management Program to be fully covered under the Plan. For example, scheduled inpatient surgery, MRIs and MRAs are required to be Pre-Certified. Failure to Pre-Certify may result in a reduction or denial of benefits.

**Provider** means a Hospital or Facility or other appropriately licensed or certified professional health care practitioner. Empire BlueCross BlueShield will pay benefits only for covered services within the scope of the practitioner's license. For behavioral health care purposes, "Provider" includes psychiatrist, psychologists and certified social workers with six or more years of post-degree experience, who are certified by the New York State Board for Social Work or a comparable organization outside New York to provide psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. 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.

**Skilled Nursing Facility** is a licensed institution (or a distinct part of a Hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.

**Specialist** is a licensed Doctor whose practice is limited to a particular branch of medicine or surgery and is based upon advanced training, certified by a specialty board as being qualified to limit his/ her practice.

**Treatment Maximums** are the maximum number of treatments or visits for certain conditions.

**Union** means the Northeast Regional Council of Carpenters affiliated with the United Brotherhood of Carpenters and Joiners of America or Local Unions 279 and 290.

# About Your Participation

This Section explains the rules that govern your eligibility for benefits under the Plan.

**When Your Participation Begins**

You initially become eligible to receive benefits from the Fund on the first day of the month after you have worked at least 700 hours in Covered Employment during two consecutive Half Years and contributions for those hours have been received by the Fund. You will not be eligible for benefits until contributions are actually received by the Fund Office. If the Fund Office receives contributions on your behalf later than the date on which they are due, your participation will commence retroactive to the first day of the month after you have worked the required 700 hours for which contributions have been received.

Once you become eligible to participate, you will receive coverage for the rest of the Half Year in which your participation began. For example, if the Fund has received contributions by November 15, 2017, for 700 hours of work performed during two consecutive Half Years (January 1-June 30 and July 1-December 31, 2017), your coverage will start for you and your Dependents beginning December 1, 2017 and will continue for the remainder of that Half Year, which ends on December 31, 2017. After that coverage for benefits will continue as long as you meet the requirements for continuing eligibility, which are described on page 13 of the SPD. The Fund may not notify you immediately upon the commencement of your coverage. You should monitor the hours you work in Covered Employment and discuss any questions you have about the start of your benefits with the Fund Office.

Both for the purposes of determining initial eligibility and continuing eligibility (as described on page 13), the Fund will include hours you work under the jurisdiction of another fund that is party to a reciprocity agreement with this Fund if contributions made to that other fund are properly transferred to this Fund consistent with the provisions of the applicable Reciprocity Agreement. If you earn hours under another such fund, you must submit a properly completed Reciprocal form to the Fund Office as soon as possible, but no more than 60 days after you begin working in the jurisdiction of the other fund. A Reciprocal form is available from the Fund Office or on the Fund's website at www.nrccf.org.

Previous hours worked in Covered Employment cannot be banked for determining eligibility. This means that if you previously worked in Covered Employment but failed to become eligible for benefits because you did not earn enough hours, those previously worked hours cannot be used to determine your initial eligibility for benefits. In addition, you will not be credited with any hours that you work in self-employment for any purposes under the Plan.

Neither you nor your Employer is permitted to contribute to the Fund on your behalf without having an agreement with the Fund requiring such contributions. The Fund cannot give you credit for any work you do unless the work is covered by a collective bargaining agreement, participation agreement or some other written agreement between your Employer and the Fund's

Board of Trustees. Without such agreement, no credit will be given to you, even if your Employer, or you make contributions to the Fund.

An owner-operator, who is an owner of a contributing Employer and performs both Covered Employment and non-Covered Employment, is eligible to participate in the Fund pursuant to a written participation agreement with the Board of Trustees, provided the Employer makes contributions on his behalf for a minimum of 1500 hours per year.

**Continuing Your Participation**

Once you initially become eligible to receive benefits from the Fund, you must satisfy certain requirements to continue your eligibility under the Plan. Specifically, in order to remain eligible for benefits for the next Half Year, you must have worked at least 700 hours in Covered Employment during the Half Year that just ended and your contributions for those hours must have been received by the Fund. For example, to continue your coverage from January 1, 2018 through June 30, 2018, you must receive contributions for at least 700 hours of work in Covered Employment between July 1, 2017 and December 31, 2017. Alternatively, if you worked at least 1,400 hours in Covered Employment during a calendar year, you will be eligible for benefits in the next full calendar year even if you failed to work at least 700 hours in Covered Employment during the Half Year that just ended.

**You will not receive credit for hours you work for which contributions are not actually received by the Fund. If you work more hours than you need to continue your participation during either a Half Year or full calendar year, you <u>cannot</u> carry those hours forward to another period.**

For your participation in the Plan to continue under the rules described above, you must be in or available for Covered Employment within the jurisdictional area of the Northeast Carpenters Funds on each work day during that year (unless you are working in the jurisdiction of a health fund that has a reciprocal agreement with the Fund and contributions are transferred to this Fund). If you cease to work in Covered Employment and are not available for work in Covered Employment, your Plan participation ends on the last day of the month following the month you were no longer available for employment.

**Self-Pay**

You will only receive credit for contributions actually received by the Fund. However, if you have at least one hour in Covered Employment but do not satisfy the hours requirement in any period (700 hours in a Half year or 1400 hours in a calendar year), you will be able to continue health benefits for you and your dependents if you choose to self-pay. If you want to self-pay to continue your medical coverage, an election form and full payment must be received by the Fund Office within 30 days of the date on which you are notified about your self-payment option. If you are a Participant in the Northeast Carpenters Annuity Fund, you may also be able to withdraw money from your Annuity Fund account to self-pay (contact the Annuity Fund for more information). Self-pay is not permitted if you are a retiree or an owner/operator and your company is delinquent in contributions to this Fund or to the Northeast Carpenters Pension, Annuity or Apprenticeship Training Funds. The amount you will be required to pay is equal to

the difference between the amount your employer would have been required to contribute during the preceding half-year period or calendar year to maintain your coverage and the amount your employer actually paid on your behalf during that period.

The following example illustrates how self-pay works:

| | |
|---|---|
| Amount of hours required to continue eligibility for 2017 calendar year: | 1400 |
| Number of hours for which employer made contributions: | 1300 |
| Number of hours "short" for continued eligibility: | 100 |

Most recent contribution rate: $11.25

X

Amount of hours "short" 100

Amount of self-pay required for continued eligibility for 2017 calendar year is $1,125.00.

**Workers' Compensation**

If you are receiving Workers' Compensation benefits, you will be credited with hours of Covered Employment at the rate of seven hours per workday (Monday through Friday) for each workday on which you receive Workers' Compensation if you would not otherwise be eligible for coverage under the Plan during the eligibility period. You will not receive credit for more than 130 workdays per calendar year. The 130 day maximum is for credit for Workers' Compensation and Disability combined. You must continue to receive Workers Compensation benefits during this period to remain eligible for coverage. Your coverage under the Plan will end on the date your Workers Compensation benefits cease or 130 days, if earlier. To be eligible for this continued coverage, you must submit proof to the Fund Office of your receipt of Workers' Compensation benefits.

**New York State Disability**

If you receive New York State Disability Income while receiving disability coverage under the Plan, and while you are eligible for coverage under the Plan, you will be credited with hours of Covered Employment at the rate of seven hours per workday (Monday through Friday) for each workday on which you receive these state benefits if you would not otherwise be eligible for coverage under the Plan during the eligibility period. You will not receive credit for more than 130 workdays per calendar year. The 130 day maximum is for credit for Workers' Compensation and Disability combined. To be eligible for this continued coverage, you must submit proof to the Fund Office of your receipt of New York State Disability Income benefits.

You are eligible to receive credit under this Section of the SPD only if your period of total disability begins both while you are a Participant and while you were working in Covered Employment.

Your completed application for coverage from the Fund while receiving Disability Income benefits must be received by the Fund Office before coverage can be considered. Once a properly completed application is received, your coverage will be retroactive to the date on which you meet

all the eligibility requirements for this coverage. Please contact the Hauppauge Fund Office for an application or visit its website at www. nrccf.org.

**Unemployment**

You will not receive credit for eligibility purposes for hours of unemployment.

**Covered Employment and Apprenticeship Training.** For the purposes of continued eligibility in the Northeast Carpenters Health Fund, hours spent in the Apprenticeship training program of the Northeast Carpenters Apprenticeship Fund will be credited as covered employment at a rate of one hour for every hour spent in training, for up to 35 hours per week, with a maximum of 140 hours per calendar year.

**Disqualifying Employment**

If you work in Disqualifying Employment, your coverage will be suspended, as explained below. Disqualifying Employment means any employment or self-employment before age 65 in an industry covered by the Plan and in the geographic area covered by the Plan. Disqualifying Employment can be work performed for a Union or non-Union employer, whether or not the work is performed on a construction jobsite where carpenters covered under this Plan are employed, except that Disqualifying Employment shall not include any work as a supervisor, project manager or estimator for a Contributing Employer or other employer party to a collective bargaining agreement with a local union or district council of the United Brotherhood of Carpenters, Post-retirement work as a foreman will be considered Disqualifying Employment, even if performed for a union contractor. However, for purposes of the Health Fund, Disqualifying Employment does not include Covered Employment -- that is, work for which Employer contributions are due to the Health Fund on your behalf -- even if it is Disqualifying Employment under the Pension Fund and results in a suspension of your pension benefit.

**Suspension of Coverage for Work in Disqualifying Employment**

Your benefits will be suspended for work in Disqualifying Employment before age 65 as explained below. However, if you work in Covered Employment (for which contributions are due to the Northeast Carpenters Health Fund on your behalf), your benefits will not be suspended.

Before age 62, your benefits will be suspended for any month in which you worked or were paid for more than 40 hours of service (as defined in the Pension Plan) in Disqualifying Employment. From age 62 to age 65, your benefits will be suspended for any month in which you worked or were paid for more than 40 hours of service in Disqualifying Employment after you have reached the earnings limit applicable to recipients of Social Security retirement benefits in the Plan Year. Benefits will not be suspended on and after age 65.

If you work in Disqualifying Employment as described above, then:

1. All benefits provided under this SPD will be suspended, regardless of the number of hours you worked during the last year or Half Year period;

2. Your ability to make self-payments to continue coverage will be lost;

3. Your Supplemental Health Reimbursement Account balance will be suspended; and

4. You may not use the balance in your Supplemental Health Reimbursement Account to pay for any Eligible Medical Expenses or COBRA premiums.

This means that if you work in Disqualifying Employment, you and your Dependents will not receive any benefits offered by the Fund. In addition, you will not receive any reimbursements from your Supplemental Health Reimbursement Account for any reason. You are required to notify the Fund at least 10 days before you commence work in Disqualifying Employment. If you are not sure whether certain employment is Disqualifying Employment, you should contact the Fund Office. If you fail to notify the Fund of your work in Disqualifying Employment and any claims are paid, or reimbursements are made on your behalf, or on behalf of your Dependents, for services incurred while you are working in Disqualifying Employment, such payments will be treated as overpayments and you are responsible to reimburse the Fund for the total amount paid by the Fund, according to the provisions of the Fund's collection policy and to the extent permitted by law.

**Reinstatement of Coverage after Disqualifying Employment**

Once you terminate Disqualifying Employment, your coverage will be reinstated consistent with the Fund's reinstatement rules below.

**When Your Participation Ends**

If you do not meet the requirements for continued coverage (as described above) when the Fund reviews its records at the end of each Half Year, your participation will stop at the end of the Half Year.

**Reinstatement of Coverage**

Once your coverage ends, your benefits may be reinstated only if contributions are received by the Fund on your behalf for at least 700 hours of work in Covered Employment during two consecutive Half Years while you are not eligible for benefits under the Plan. Your coverage will be reinstated prospectively on the first day of the next month after you meet this requirement. The Fund may not notify you immediately upon the reinstatement of your coverage. You should monitor the hours you work in Covered Employment and discuss any questions you have about your reinstatement of eligibility with the Fund Office.

## Dependent Participation

Your eligible Dependents will begin receiving benefits under the Plan on the same day your participation begins, and their participation will continue for as long as you remain a Participant and they remain eligible Dependents. You cannot enroll Dependents unless you are participating in the Plan. You may be required to provide periodic proof that your Dependents continue to meet the requirements for coverage. Your eligible Dependents include your lawful spouse and your children, as defined below.

1. **Your lawful spouse** is the person to whom you are legally married, unless you are legally separated. If you reside in New York, you will be considered to have legally separated on the date your decree or separation is entered by the court or the date on which your separation agreement is filed with the court. If you are legally separated, your spouse is not eligible for benefits under the Plan. If you fail to notify the Fund of your legal separation or divorce and any claims are paid, or reimbursements are made on behalf of your spouse for services incurred after his or her coverage would have terminated due to divorce or legal separation, such payments will be treated as overpayments and you are responsible to reimburse the Fund for the total amount paid by the Fund, according to the provisions of the Overpayment section of this SPD. Spouses of the same gender are considered lawful spouses for all purposes under this Plan if they were legally married under the laws of the jurisdiction in which the marriage ceremony took place.

2. **Non-Disabled Child** is your biological child, stepchild, adopted child, a child placed with you in anticipation of adoption. A non-disabled child is eligible for coverage until the last day of the month in which the child attains age 26. For dental benefits, a child's eligibility for benefits is determined under the insurance contract with Cigna.

3. **Disabled Child**. If your unmarried child turns age 26 while covered under the Plan and is, at that time, incapable of self-sustaining employment due to a physical or mental disability, the child will continue to qualify as an eligible dependent for as long as the child remains disabled and you remain covered under the Plan. You must submit written proof of incapacity to the Fund Office within 31 days of the date the child's eligibility would have otherwise ceased. Unless the child has been determined by the Social Security Administration to be permanently disabled, the Fund will require annual certification of disability. If proof is not sufficient or is not timely submitted, coverage will terminate.

   The Board of Trustees, in its sole and absolute discretion, will determine whether a child is considered disabled under this provision.

Your Dependents will generally receive the same benefits as you, but there are exceptions, such as Disability Income and Life Insurance. Refer to the chart on pages 25-26 to find out the benefits for which your Dependents are not eligible.

To be considered a Dependent, your spouse and/or child must be a citizen, national or resident of the United States, unless such individual is a resident of Mexico or Canada, except that an adopted child may still be considered a Dependent if the child has the same principal residence as the Participant and the Participant is a citizen or national of the United States.

**Enrolling dependents after they are first eligible.** If you decide not to enroll your Dependents when they are first eligible for coverage because they have other health insurance coverage, you may do so at a later date as long as it is within 30 days after the other coverage ends. If you enroll them within this 30-day period, their coverage will be retroactive to the date on which their other coverage terminated. If you do not enroll your Dependents within this 30-day period, their coverage will not begin until you have notified the Fund and completed all the necessary forms. In this case, coverage will be prospective only. In addition, if you acquire a new Dependent as a result of marriage, birth, adoption or placement of a child with you for adoption, you can enroll your new Dependent retroactive to the date he/she attained dependent status as long as you enroll your Dependent within 30 days after the marriage, birth, adoption or placement for adoption. If you do not enroll a new Dependent within this time period, their coverage will begin on the first day of the month after you properly notify the Fund and enroll them in the Plan and will be prospective only.

If, after your coverage under the Plan becomes effective, you or your Dependent(s) lose eligibility for Medicaid or coverage under the Children's Health Insurance Program (CHIP) or becomes eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll yourself and/or your Dependents in the Plan, it is your responsibility to notify the Fund immediately of such change and complete the appropriate forms. If you notify the Fund and properly complete the enrollment forms within 60 days of the loss of Medicaid/CHIP or of you or your Dependents' becoming eligible for a state subsidy, coverage for you and/or your Dependent will begin as of the date you or your Dependents lost eligibility for Medicaid/CHIP or the date you or they became eligible for the subsidy. If you do not notify the Fund within this 60-day period, coverage for you and/or your Dependent will begin on the first day of the month after you notify the Fund and properly enroll yourself and/or your Dependents in the Plan.

**When Dependent Participation Ends**

Dependent coverage ends when your coverage ends or when a Dependent no longer satisfies the eligibility requirements for being a Dependent.

- Your spouse's coverage ends on the date of your divorce or legal separation, determined under the laws of the state in which you live.
- Your child's coverage ends on the end of the month in which your child reaches age 26, or later if the child no longer satisfies the rules for disability as described on page 17.

## Qualified Medical Child Support Orders

Benefits or payments under this Plan are not assignable to anyone other than a health care provider, except as required by law. Benefits are also not subject to claims of creditor and cannot be assigned by legal process except under a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a state court or agency that requires an employee to provide coverage under a group health plan to a child. A QMCSO usually results from a divorce or legal separation. Whenever the Fund receives a QMCSO, it will be reviewed in accordance with the Fund's QMCSO Procedures and federal law. To obtain a copy of the Fund's QMCSO Procedures, please contact the Fund Office.

## Coverage for Your Family After Your Death

If you die while covered under the Plan, coverage for your Dependents will continue until the earlier of:

- the date on which your Dependents cease to be Dependents under the Plan; or
- the end of the Half Year or full year for which you were entitled to coverage based on your hours.

Once active coverage terminates, a Dependent spouse or child can continue coverage under a retiree plan, provided he/she self-pays the required premiums for retiree coverage, or elect COBRA coverage (described below).

## Continued Coverage During a Family and Medical Leave

The Family and Medical Leave Act ("FMLA") of 1993 allows certain eligible Participants to take unpaid leave for up to 12 weeks during any 12-month period due to:

- The birth, adoption or placement with you for adoption of your child;
- To provide care for a lawful spouse, child or parent who is seriously ill;
- Your own serious illness; or
- A qualifying exigency that arises in connection with the active military service of your child, spouse, or parent. A qualifying exigency includes a) notification of military deployment within 7 days of the deployment date; b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; d) making financial and legal arrangements; e) attending counseling sessions; f) up to 5 days of rest and recuperation; g) attendance at post-deployment activities.

You may be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service.
During FMLA leave, you can continue your coverage under this Plan provided your Contributing Employer properly grants your FMLA leave and makes the proper notification and payments to the Fund. You should contact the Fund office with any questions regarding your coverage during FMLA.

**Continued Coverage During Military Leave**

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to participants who are absent from employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

**Coverage Under USERRA.** A Participant who is absent from employment by reason of service in the uniformed services can elect to continue coverage for the Participant and his or her eligible Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which the Participant's absence begins and ends on the earlier of:

- The end of the 24-month period beginning on the date on which the absence begins; or
- The day after the date on which the Participant is required to but fails to apply under USERRA for or return to a position of employment covered under the Fund.

This right to temporarily continue group health coverage does not include any life insurance benefits, , accident and sickness benefits or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, Participants and Dependents also may have rights to elect continuation coverage under COBRA.

**Notice and Election of USERRA Coverage.** The Participant must notify the Fund Office of his absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If the participant wishes to elect USERRA coverage, he must make such election in writing with the Fund Office within 60 days of the last day of employment.

**Paying for USERRA Coverage.** The Participant may be required to pay all, or a portion of, the cost of these benefits. If the period of military service is less than 31 days, there is no charge for this coverage beyond the normal Deductible or Co-payments that would be paid if the Participant was employed. If the military service extends more than 31 days, the Participant must pay 102% of the cost of the coverage unless the employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be

provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to timely pay for coverage. The Fund will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to untimely payment.

When you return to Covered Employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage for the period of eligibility remaining when you began your qualified military service. For example, assume you were eligible for coverage from January 2016 through June 2016 because you earned sufficient hours in Covered Employment during the previous Half Year. On March 31, 2016, you left Covered Employment for qualified military service and properly elected USERRA coverage (leaving three months of coverage remaining). If you return to Covered Employment consistent with the requirements of federal law, you can continue your coverage under the Plan for three months upon your return. After those three months expire, you are required to meet the requirements for as described on page 12. Alternatively, you can choose to apply these three months to give yourself free coverage for the first three months of your USERRA leave. In that case, you will not receive benefits upon your return to Covered Employment. Rather you will be required to meet the requirements for continued eligibility. You must notify the Fund which option you choose at the time you elect USERRA coverage.

In addition, any hours you work in the Half Year that your qualified military service begins will be carried over to the Half Year in which you return to Covered Employment, provided you receive an honorable discharge and return to Covered Employment within the time period required by law. For example, assume that in the example in the preceding paragraph you work 350 hours in Covered Employment from January, 2016 through March 31, 2016. Also assume that you timely return to Covered Employment on April 1, 2017 and between that date and June 30, 2017, you work 350 hours. In this case, your hours worked before and after your qualified military leave will be aggregated and you will be considered to have earned 700 hours during the Half Year period beginning January 1, 2017. However, your pre-military hours will only be aggregated with the hours you earn in the Half Year in which you return to work. They cannot be carried over to any other future Half Years.

**Continued Coverage Under COBRA**

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on a self-pay basis, in certain situations when coverage would otherwise end. “Health coverage” includes Hospital, medical, substance abuse, prescription drug and vision coverage. If you previously elected dental coverage, you can also elect COBRA for dental.

You need not prove that you are in good health to elect COBRA coverage, but you do need to meet the eligibility requirements and you must apply for the coverage. The Fund can terminate your COBRA coverage retroactively if you are determined to be ineligible for COBRA. The following chart shows when you and your eligible Dependents may qualify for COBRA and for how long coverage may continue. The following chart is a general summary of COBRA. You should contact the Fund Office with any questions.

**COBRA CONTINUATION OF COVERAGE**

| **Coverage May Continue For** | **If** | **Maximum Days** |
|---|---|---|
| You and your eligible Dependents | Your employment terminates for reasons other than gross misconduct | 18 months* |
| You and your eligible Dependents | You become ineligible for coverage due to a reduction in your employment hours | 18 months*,** |
| Your Dependents | You die | 36 months |
| Your Spouse | You divorce or legally separate or your marriage is civilly annulled | 36 months |
| Your Dependent children | Your dependent children no longer qualify as Dependents (for example, they reach age 26) | 36 months |
| Your Dependents | You become covered for Medicare benefits | 36 months |

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

** For a qualified spouse or Dependent child whose continuation is due to an employee's termination of employment or reduction in employment hours, the continuation period may be extended if another qualifying event occurs during the 18-month COBRA period. Coverage may be extended for up to 36 months from the date they first qualified.

**Enrolling a New Dependent.** If you marry, have a newborn child or have a child placed with you for adoption while you are covered under COBRA, you may enroll that new Dependent for coverage for the balance of the COBRA continuation period, on the same terms applicable to your COBRA coverage.

**FMLA Leave**. If you do not return to Covered Employment after your FMLA leave of absence, you become eligible for COBRA coverage as a result of your termination of employment. For the purposes of COBRA, your employment is considered terminated at the end of your FMLA leave or the date that you notify your Employer that you will not be returning to Covered Employment.

**Notification of a Qualifying Event**. In order to have a right to elect COBRA, you or your Dependents are responsible for notifying the Fund of your divorce or legal separation, your child losing dependent status or if you become disabled as determined by the Social Security Administration. You or your Dependents must notify the Fund Office in writing of any of these events no later than 60 days after the date the event occurs or 60 days after the date that coverage would terminate under the Plan because of the event, whichever occurs later. Your notice must include your name and the name of your Dependents who want COBRA coverage and their relationship to you, the date of your COBRA qualifying event and the qualifying event that occurred.

Although your Employer is responsible to notify the Fund of your death, termination of employment or reduction in hours of employment, you (or your beneficiary in the event of your death) should also notify the Fund to make sure the Fund has received timely notice. Your Employer must notify the Fund within 30 days of your loss of coverage. Once notified, the Fund will send you a COBRA notice within 30 days.

**Making an Election**. Once the Fund is notified of your COBRA qualifying event, you will receive a COBRA notice and election form. In order to elect COBRA, you or your Dependents must submit the COBRA election form to the Fund Office within 60 days after the date you would lose health coverage under the Fund or 60 days from the date you receive the COBRA notice, whichever is later.

**Failure to Give Timely Notice**. If written notice of a qualifying event is not given within the time periods described above, and as a result, the Fund pays claims for a terminated individual, the Participant and any Dependents related to the Participant, are required to reimburse the Fund for any claims that should not have been paid. Such payments will be considered Overpayments under that section of the SPD. If the Fund is not reimbursed, all amounts due may be deducted from the Participant's Supplemental HRA or from future benefits payable on behalf of the Participant, that person or any other Dependents related to the same Participant.

Each of your eligible dependents has an independent election right for COBRA coverage.

**Paying for COBRA coverage.** If you or your Dependents elect to continue coverage, they or you must pay the full cost of the coverage elected. The first payment is due no later than 45 days after the election for coverage is received by the Fund Office. Thereafter, payments are due on the first day of each month and are considered to be on time if they are made by the 30$^{th}$ day of each month. Costs may change from year to year.

If you fail to notify the Fund of your decision to elect COBRA continuation coverage or you fail to make the required payment within the required time periods, your Fund health coverage will end.

**What COBRA coverage provides.** The COBRA continuation coverage generally is identical to the current coverage the Plan provides for similarly situated employees or family members, except Life Insurance and Disability Income Benefits are not available under COBRA. Dental benefits are subject to a separate election. If, during the period of COBRA continuation coverage, the Plan's

benefits change for active employees, the same changes will apply to COBRA participants.

**When COBRA coverage ends.** COBRA coverage ordinarily ends at the end of the maximum coverage period specified in the chart on page 22. It will stop *before* the end of the maximum period under any of the following circumstances:

- failure to make the required payments on a timely basis; or
- a COBRA participant becomes covered under Medicare or another group plan.

Once COBRA coverage terminates, it cannot be reinstated unless otherwise permitted by law.

**Retirees**

Limited benefits are available to eligible retirees and their Dependents. The Fund maintains separate Summary Plan Descriptions for retirees. If you have any questions about the benefits available to retirees, please contact the Fund Office.

# Overview of Your Active Health Fund Benefits

The charts below list the different benefits available under the Plan and the eligibility rules for each type of benefit. It also advises of your out of pocket costs, if any, for these benefits and any limits that apply.

**Please note that for Out-Of-Network Benefits, you are responsible to pay any amount charged by your Provider that exceeds the reasonable and customary charges for the services rendered, in addition to any Co-Insurance, Deducible and Co-payments that are required under the Plan**.

| BENEFITS FOR ACTIVE PARTICIPANTS | | | |
|---|---|---|---|
| **Benefit** | **How It Works In General** | **Who's Eligible** | |
| | | **EMPLOYEES** | **DEPENDENTS** |
| **Medical**<br>hospitalization, major medical, Doctor treatment, chiropractic treatment | **In-Network**<br>When you go to an In-Network provider for your care, the Plan pays 100% of the reasonable and customary charges for hospital care and, after a $20-per-visit copayment, 100% of most other eligible medical expenses (subject to Plan limits). For emergency room visits, you are required to pay a $100 per-visit co-payment (waived if admitted). Your out-of-pocket in-network expenses are capped at $3,000 individual/$6,000 family per year for medical expenses.<br><br>**Out-of-Network**<br>When you go to an Out-of-Network provider for your care, the Plan pays 100% of the reasonable and customary charge for hospital care; after a $150/individual or $300/family annual deductible, the Plan pays 70% of the reasonable and customary charge for most other eligible medical expenses (subject to Plan limits). Your 30% share is capped at $5,000 per person per year; that is, once a covered person has paid $5,000 in a year as his/her 30% share of the reasonable and customary charge for eligible out-of-network medical expenses, the Plan pays 100% of the reasonable and customary charge for eligible medical expenses for that person for the rest of the year, unless coverage is terminated earlier under the rules of the Plan. Hospital Emergency treatment is provided on an in-network basis, | Yes | Yes |
| **Prescription Drug** | **Retail**<br>When you fill your prescriptions at a participating retail pharmacy, you pay a $9.00 copay for generic prescription, 20% coinsurance for brand name prescription, and 20% coinsurance for specialty drugs through Accredo . You can get up to a 34-day or 100-dose supply per prescription, whichever is less.<br><br>**Mail Order**<br>When you fill your prescriptions through the Mail Order Program, you pay **a** $22.50 copay for generic prescriptions, 20% coinsurance for brand name prescriptions, and 20% coinsurance for specialty drugs through Accredo;. You can get up to a 90-day supply per prescription.<br><br>Your out-of-pocket in-network expenses for prescription drugs are capped at $3,600 individual, $7,200 family per year. | Yes<br><br>Yes | Yes<br><br>Yes |
| **Dental** | You may enroll in a dental plan insured by CIGNA (HMO or PPO), and your premiums can be deducted from your Supplemental HRA. | Yes | Yes |

| BENEFITS FOR ACTIVE PARTICIPANTS | | | |
|---|---|---|---|
| **Benefit** | **How It Works In General** | **Who's Eligible** | |
| | | **EMPLOYEES** | **DEPENDENTS** |
| **Vision** | The Plan covers one eye exam per year with a Davis Vision provider, subject to a $20 co-payment. The Plan also covers one pair of basic eyeglasses and frames per year subject to a $20 co-payment, or one set of contact lenses, ordered through a Davis Vision provider. There are no out-of-network benefits. | Yes | Yes |
| **Employee Assistance Program** | The Plan pays for eligible expenses to treat alcohol and drug abuse. | Yes | Yes |
| **Disability Income** | If you become totally disabled and are unable to work in employment covered by the Plan, the Plan pays $140.00 a week for up to 26 weeks of disability. | Yes | No |
| **Life Insurance** | $30,000 of life insurance provided by Dearborn payable to your beneficiary upon your death, subject to the terms of the policy. . | Yes | No |

# Medical Benefits

This Section describes Plan provisions for hospitalization, major medical, Doctor treatment, chiropractic treatment and how the provider network operates.

**Charges must be necessary and reasonable.** To be covered under the Plan, all charges must be reasonable for the care of a covered person as the result of an injury, pregnancy or sickness. Any portion of a charge that the Fund considers to be unreasonable will not be covered. In addition, the Plan will pay benefits only for services and supplies determined to be Medically Necessary. The fact that an In-Network Provider prescribed, recommended or approved a service, supply or equipment does not, in itself, make it Medically Necessary.

**Charges must be less than the Maximum Allowable Charge.** For the purpose of determining the amount of coverage, the Maximum Allowable Charge for any supply or service shall be the lesser of:

- the usual and customary rate for that service or supply;
- an amount determined by the Board of Trustees as reasonable and customary for that procedure;
- the amount normally charged by a selected segment of Doctors or other providers in a given geographic area (such segment and area as defined by the Board of Trustees).

When determining the Maximum Allowable Charge, the Board of Trustees may consider the condition being treated and any medical complications or unusual circumstances that require additional time, skill or experience.

**Charges must be incurred while covered.** The Fund will not cover any expenses incurred by a person while such person is not covered under the Plan

**Pre-certification.** For certain services, the Fund requires Pre-certification in order for the maximum coverage to be provided. Pre-certifying your services limits your exposure to unnecessary risk by confirming in advance the need for proposed treatment. When you use an In-Network Provider, the provider generally will do the Pre-certification for you. When you use an Out-of-Network Provider, it is your responsibility to have the required services Pre-certified. If you fail to do so, benefit payments will be reduced by 50%, up to a $500 maximum reduction, for each admission, treatment or procedure that you fail to Pre-certify. If the admission or procedure is not Medically Necessary or is not covered under the Plan for some other reason, no benefits will be provided.

**When Pre-certification is required.** The following medical services are required to be Pre-certified (this is not intended to be an inclusive list):

- admissions to the Hospital, whether planned or on an emergency basis;
- ongoing hospitalization and discharge planning;
- Ambulatory Surgery;
- high risk pregnancies;
- routine maternity admissions;
- illness or injury to newborns;
- hospice or Skilled Nursing Facility admissions;
- home health care and home infusion therapy;
- inpatient physical therapy;
- cardiac rehabilitation;
- MRI or MRA exams;
- prosthetics, orthotics or durable medical equipment (rental or purchase);

To pre-certify your care, call the Empire BlueCross BlueShield Medical Management Program at 800-553-9603 between 8:30 AM and 5:00 PM, Monday through Friday.

Your services must be Pre-certified consistent with the following schedule:

- All scheduled Hospital admissions and/or surgical procedures must be Pre-certified at least two weeks in advance or as soon as the care is scheduled, if earlier;
- emergency hospital admissions must be Pre-certified within 24 hours after admission or as soon as reasonably possible;
- maternity admissions must be Pre-certified within the first three months of pregnancy;
- all other services and supplies that require Pre-certification must be Pre-certified as soon as reasonably possible.

Please see the Plan's rules beginning on page 43 for information regarding Pre-certification of mental health benefits.

Once your Pre-certification request has been submitted, the Empire BlueCross BlueShield Medical Management Program will review the proposed care to certify the length of stay or number of visits (as applicable) and will approve or deny coverage for the procedure based on

Medical Necessity. You will receive a written statement of approval or denial within three business days after all necessary information has been received.

# General Exclusions

The following are general exclusions that apply to all sections of the Plan. These services are not eligible for coverage.

- Expenses incurred before an individual became eligible for coverage under the Plan, unless otherwise specified;
- Treatment that is not Medically Necessary;
- Expenses that are beyond what is reasonable and customary or that exceed the Maximum Allowed amount;
- any treatment rendered by the patient's relative (spouse, child, brother, sister, parent, or in-law);
- injury or illness which arises out of, or in the course of, any occupation or employment for wage or profit for which there is Workers' Compensation or Occupational Disease Law coverage;
- injury or illness which arises out of, or in the course of, any war, or any act of war (declared or undeclared) or military service of any country;
- injury or illness which arises out of a criminal act by the covered person, or a self-inflicted injury or disease that is not the result of a medical condition;
- expenses for services or supplies for which a covered person receives payment or reimbursement from casualty insurance or as a result of legal action or expenses for which the covered person has been reimbursed by another party who was responsible (see page 58 for the Fund's rights of reimbursement and subrogation);
- expenses reimbursable under the "No-Fault" provisions of a state law;
- confinement in a Hospital or other Facility owned or operated by a state, province, or political subdivision, unless there is an unconditional requirement on the part of the covered person to pay such expenses without regard to any liability against others, contractual or otherwise;
- services covered under government programs, except Medicaid or where otherwise noted;
- services given by an unlicensed provider or performed outside the scope of the provider's license
- technology, treatments, procedures, drugs, biological products or medical devices that are Experimental, Investigative, except as required by law, or obsolete or ineffective. Also excluded is any hospitalization in connection with Experimental or Investigational treatments except as required by law; and
- services usually given without charge, even if charges are billed.
- where payment under this Plan is prohibited by any law to which you or your Dependent is subject at the time expenses are incurred;
- to the extent that they are otherwise payable as described under the Coordination of Benefits provisions described on page 83; and
- any injury or illness for which a third party may be responsible, as described under the Subrogation and Reimbursement provisions on page 58.

# How Medical Expenses Are Paid

The level of coverage provided for eligible expenses depends on whether treatment is rendered by an In-Network Provider or Out-of-Network Provider.

**In-Network Coverage**

The Fund's network benefits are provided through Empire BlueCross BlueShield ("Empire"). Empire has selected Doctors, Hospitals and other providers that participate in their Exclusive Provider Organization network (EPO). When you visit an In-Network Provider, be sure to show your Empire BlueCross BlueShield ID card. When you identify yourself to network providers with your ID card, they will file all claims with the Fund on your behalf. In-Network providers are listed on the Empire BlueCross BlueShield website at www.empireblue.com. You can also request that a directory be mailed to you by calling Member Services at 800-553-9603.

When you go to an In-Network provider for your care, the Plan pays 100% of the reasonable and customary charges for hospital care and, after a $20-per-visit copayment, 100% of most other eligible medical expenses (subject to Plan limits). For emergency room visits, you are required to pay a $100 per-visit co-payment.

If you go to an In-Network provider for an emergency room visit, you will not have to satisfy a deductible—you will pay only a $20 copayment for doctor visits, and the $100 copayment for emergency room visits (the emergency room copayment is waived if the patient is admitted to the hospital within 24 hours).

**Out-of-Network Coverage**

When you go to an Out-of-Network provider for your care, the Plan pays 100% of the reasonable and customary charge for Hospital care. For Hospital emergency room visits for a medical emergency, you are required to pay a $100 per visit co-payment (waived if admitted within 24 hours).

The Plan pays 70% of the reasonable and customary charge for most other eligible medical expenses after the $150 individual or $300 family annual deductible, and subject to Plan limits. Your 30% share of costs is capped at $5,000 per person; that is, once a covered person has paid $5,000 in a year as his/her 30% share of the reasonable and customary charge for eligible out-of-network medical expenses, the Plan pays 100% of the reasonable and customary charge for eligible medical expenses for that person for the rest of the year, unless coverage is terminated earlier under the rules of the Plan.

**Please Note**: When you go to an Out-of-Network provider for your care, in addition to the reasonable and customary charge, the provider may bill you for the difference between the provider's actual charge and the "reasonable and customary charge" under the Plan. This additional charge is not paid by the Plan. This provider practice is called "balance billing".

*Annual Deductible***.** Each participant must satisfy the $150 individual annual Deductible. However, if you have family coverage, the annual Deductible is considered satisfied once your family's combined eligible expenses reach $300.

The following expenses are not applied toward the Out-of-Network annual Deductible:

- In-Network Co-payments;
- Out-of-Network expenses that exceed the reasonable and customary charge;
- amounts that you pay because you failed to meet the Pre-certification or other similar requirements; and
- charges excluded or limited by the Plan.

*Co-Insurance*. Once the annual deductible is met, the Plan pays 70% of the reasonable and customary charges for eligible Out-of-Network expenses. You pay the remaining 30%, which is your coinsurance, plus any amounts over the reasonable and customary charge. Keep in mind that there is no coverage for any service or supply that is not considered medically necessary.

**Annual out-of-pocket maximum.** The annual out-of-pocket maximum puts a limit on the coinsurance and other out-of-pocket expenses each participant has to pay in a given year. Any eligible expenses incurred after the annual out-of-pocket maximum is reached are paid by the Fund. **In-network** medical expenses and prescription drug expenses incurred after the maximum is reached are paid at 100% of the contracted rate. **Out-of-network** medical expenses after the maximum is reached are paid at 100% of the reasonable and customary charge. The Plan has the following out-of-pocket maximums, calculated for the period beginning January 1 and ending December 31 of each year:

- For in-network medical providers: **$3,000** per Individual and **$6,000** per Family
- For out-of-network medical providers: **$5,000** per Individual for each enrolled individual
- For in-network prescriptions: **$3,600** per Individual and **$7,200** per Family

The expenses listed below are not applied towards satisfying the out-of-pocket maximum requirement. In addition, it will still be your responsibility to pay these expenses even if your out-of-pocket maximum has been reached.

- Dental premiums
- Out-of-network deductibles
- Balance-billed charges
- Penalties for failure to pre-certify
- Health care costs this Plan doesn’t cover

# Eligible Medical Expenses

These are some of the most common expenses that are covered under the Plan. If you have a question about whether a particular service is covered, you should contact the Fund Office.

| ELIGIBLE MEDICAL EXPENSES | | |
|---|---|---|
| Provision | **How It Works** | |
| | IN-NETWORK | OUT-OF-NETWORK |
| How you access care | Go to any In-Network Provider | Go to any licensed/certified Doctor, Hospital or Facility |
| Basis for reimbursement | All In-Network reimbursements are based on the negotiated charge for Medically Necessary eligible expenses and subject to Pre-certification when required | All Out-of-Network reimbursements are based on the reasonable and customary charge for Medically Necessary eligible expenses and subject to the annual Deductible and to Pre-certification when required |
| **Annual Deductible**<br><br>• individual<br>• family | <br><br>N/A<br>N/A | <br><br>$150<br>$300 |
| **Co-payments**<br><br>(where applicable) | $20/visit | N/A |
| **Coinsurance**<br><br>(where applicable) | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after the Deductible is satisfied |
| Annual out-of-pocket maximums<br><br>Out-of-pocket maximums do not include: dental premiums; out-of-network deductibles; balance-billed charges; penalties for failure to pre-certify; and health care costs this plan does not cover. | $3,000/Individual and $6,000/Family for medical benefits<br><br>$3,600/Individual and $7,200/Family for prescriptions | $5,000/Individual for each enrolled individual for medical benefits |
| **Office visits** | $ 20 Co-payment per visit | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible and subject to a $70/visit Maximum Allowable |
| **Specialist visits** | $ 20 Co-payment per visit, subject to a maximum of 12 visits per year. | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible, subject to a 12-visit annual maximum. |

| | | |
|---|---|---|
| **Podiatrist visits** | $ 20 Co-payment per visit, subject to a maximum of 24 visits per year | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible, subject a 24-visit per year maximum. |
| **Chiropractic visits** | $ 20 Co-payment per visit, subject to a maximum of 30 visits per year | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible, subject to a 30-visit per year maximum. |
| **Second or third surgical opinion*** | $ 20 Co-payment per visit; waived if arranged through the Empire BlueCross BlueShield Medical Management Program | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Allergy testing** | $ 20 Co-payment per visit | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Allergy treatment** | $ 20 Co-payment per visit | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Diagnostic procedures:**<br>• X-rays and other imaging*<br>• MRIs/MRAs<br>• All lab tests | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Surgery** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Chemotherapy** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **X-ray, radium and radionuclide therapy** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **PREVENTIVE CARE** | | |
| Preventive care includes services on annual government lists subject to some age and frequency limitations. See page 37. | | |
| **Annual physical exam** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |

* Pre-certification required.

| ELIGIBLE MEDICAL EXPENSES | | |
|---|---|---|
| Provision | **How It Works** | |
| | IN-NETWORK | OUT-OF-NETWORK |
| **Diagnostic screening tests with PEMG:**<br>• Cholesterol ( two years)<br>• Diabetes<br>• Colorectal cancer<br>• Routine PSA tests in asymptomatic males | Plan pays 100% for services covered on government lists | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible for services covered on government lists. |
| **Well-woman care:**<br>• Office visits<br>• Pap smears<br>• Mammogram | • Plan pays 100% for services covered on government lists | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible for services covered on government lists. |
| **Well-child care,** immunizations, office visits and associated lab services provided within 5 days of office visit | Plan pays 100% for services covered on government lists | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible for services covered on government lists. |
| **EMERGENCY CARE** | | |
| **Hospital Emergency room*** | $100 Co-Payment per visit (waived if admitted to the same Hospital within 24 hours) | |
| **Office visits** | $ 20 Co-payment per visit | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Ambulance** (local professional ground ambulance to the nearest Hospital or air ambulance* to nearest acute care Hospital for emergency or inpatient admissions) | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **MATERNITY CARE** | | |
| **Office visits** for prenatal and postnatal care | $20 Co-payment for the first prenatal visit; then Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Diagnostic procedures:**<br>• Sonograms<br>• Lab tests<br>• Other diagnostic procedures | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Routine newborn in-hospital nursery care** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |

* Pre-certification required.

| ELIGIBLE MEDICAL EXPENSES | | |
|---|---|---|
| Provision | **How It Works** | |
| | IN-NETWORK | OUT-OF-NETWORK |
| **Obstetrical care* (in Hospital or birthing center)** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **IN-PATIENT HOSPITAL CARE*** | | |
| **Anesthesia and oxygen** | Plan pays 100% | Plan pays70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Blood work** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Cardiac rehabilitation** | $20 Co-payment per outpatient visit | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Chemotherapy and radiation therapy** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Diagnostic x-rays and lab tests** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Drugs and dressings** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **General, special and critical nursing care** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Intensive care** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Kidney dialysis** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Pre-surgical testing** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Semi-private room and board** | Plan pays 100% | Plan pays 100% |
| **In-hospital services of licensed Doctors and surgeons** | Plan pays 100%, subject to a maximum of 2 visits per day. | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible, subject to a $125/visit Maximum Allowable Charge |

* Pre-certification required.

| ELIGIBLE MEDICAL EXPENSES | | |
|---|---|---|
| Provision | **How It Works** | |
| | IN-NETWORK | OUT-OF-NETWORK |
| **Surgery** (inpatient or outpatient; benefits are limited for multiple surgeries through the same incision) | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **DURABLE MEDICAL EQUIPMENT AND SUPPLIES** | | |
| **Durable medical equipment*** (such as wheelchairs and hospital beds) | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible (benefits for durable medical equipment for the injection of insulin will be covered once in a 5-year period) |
| **Orthotics*** | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Prosthetics*** (such as artificial limbs) | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **Medical supplies** (such as catheters and syringes) | Plan pays 100% | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible |
| **SKILLED NURSING AND HOSPICE CARE FACILITIES** | | |
| **Skilled Nursing Care Facility*** | Plan pays 100%, subject to a maximum of 60 days per year | Plan pays 100% of the reasonable and customary charges subject to a maximum of 60 days per year |
| **Hospice care facility*** | Plan pays 100%, subject to a lifetime maximum of 210 days | Plan pays 100% of the reasonable and customary charges subject to a lifetime maximum of 210 days (bereavement counseling is limited to 5 visits) |
| **HOME HEALTH CARE** | | |
| **Home health care visits*** | Plan pays 100%, subject to a maximum of 200 visits per year | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible, subject to a maximum of 200 visits per year |
| **Home infusion therapy** | Plan pays 100% | Not covered |
| **PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY** | | |
| **Physical therapy and rehabilitation*** • Inpatient services • Outpatient services | • Plan pays 100% for in-patient services • $20 Co-payment per visit for out-patient services • Maximum of 30 visits per year | Plan pays 70% of the reasonable and customary charges, subject to a $70/day Maximum Allowable Charge and a 30-day per year maximum |
| **Occupational, speech or vision therapy*** | $ 20 Co-payment per visit, subject to a maximum of 30 visits per year | Plan pays 70% of the reasonable and customary charges after satisfaction of the Deductible, subject to a maximum of 30 visits per year |

* Pre-certification required.

| ELIGIBLE MEDICAL EXPENSES | | |
|---|---|---|
| Provision | **How It Works** | |
| | IN-NETWORK | OUT-OF-NETWORK |
| **Autism Therapy** | $20 Co-payment per visit | Plan pays 70% of the reasonable and customary charges after the satisfaction of the Deductible |

**MENTAL HEALTH CARE**

The Fund covers mental health treatment on both an inpatient and outpatient basis to the same extent it covers inpatient and outpatient medical care. This means that the same financial terms and treatment limitations that apply to medical care will also apply to mental health and substance abuse care.

| **ORGAN AND TISSUE TRANSPLANTS*** | | |
|---|---|---|
| **Organ and tissue Procurement** | Plan pays 100% of eligible transplant-related expenses as long as they are coordinated and approved by the Empire BlueCross BlueShield Medical Management Program and provided by Empire Centers of Excellence** | Plan pays 100% of the reasonable and customary charges after satisfaction of the Deductible, up to $10,000 per Transplant |
| **Transportation, lodging and meals** | | Plan pays 100% of the reasonable and customary charges after satisfaction of the Deductible up to $10,000 per Transplant Benefit Period and to $250 per day |
| **Private duty nursing** | | Plan pays 100% of the reasonable and customary charges after satisfaction of the Deductible up to $5,000 per Transplant Benefit Period |
| **Other charges** | | Plan pays 100% of the reasonable and customary charges after satisfaction of the Deductible |

* Pre-certification required.
** Empire Centers of Excellence are a national and local organ transplant network that gives members access to hospitals and medical professionals with demonstrated expertise and success in performing organ transplants.

**Preventive Care**

**In-Network**

The Plan covers a number of preventive care services with In-Network providers without any cost-sharing (co-pay) for you or your dependents. These services include annual physical exams and certain screenings, tests, vaccines, to the extent such services are included on the government's lists below, provided the services have been included on the list for at least one year prior to the Fund's Plan Year (January 1-December 1). For example, if a preventive service was added to one of the lists in September 2015, it would be covered with an In-Network provider with no cost-sharing beginning January 1, 2017. The applicable lists are:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B;
- Recommended Immunizations of the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention; and
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

You can access these lists at www.healthcare.gov.

To the extent a recommended preventive service is provided as part of a regular office visit with your provider, the applicable copay for office visits under the Plan will still apply to the extent permitted by law. However, you will not be responsible for any additional copays or coinsurance with respect to any of the preventive services referenced in the lists above if you use a provider that participates in the Empire Blue Cross Blue Shield Network. To the extent that you use an Out-of-Network provider for any preventive care service, the Plan's co-insurance and deductible requirements still apply.

**Please note that the lists of preventive services include certain age, frequency, and other limitations that may affect your ability to receive coverage for the service without cost sharing. If you do not satisfy these limitations, you may incur out-of-pocket expenses.**

If you have questions about whether a particular service is covered by an In-Network Provider with no cost-sharing, please contact BlueCross and BlueShield at 1-800-553-9603.

**Out-of-Network**

The Plan covers the same preventive services on out-of-network basis as it does on an in-network basis described above, including routine physicals for all covered persons. The Plan pays 70% of the reasonable and customary charges after you have satisfied the Deductible.

**Emergency Care**

The Plan covers emergency care, including Doctors' charges to treat an emergency condition in a Hospital, urgent care Facility or Doctor’s office. You are required to pay a $100 Co-payment for

services to treat an emergency in a Hospital (either In-Network or Out-of-Network). This Co-payment is waived if you are subsequently admitted to the Hospital within 24 hours of the emergency visit.

For other emergency care services, such as a Doctor's Office visit, if you go to an In-Network provider, you will pay a $20 co-payment; if you go to an Out-of-Network provider, you will pay 30% of the reasonable and customary charge after the deductible.

To be covered as emergency care, the treatment must be for a condition whose symptoms are so severe that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to would:

- place the patient's health in serious jeopardy;
- cause serious problems with the patient's body functions, organs or parts;
- cause serious disfigurement; or
- place others or oneself in serious jeopardy, in the event of a behavioral health emergency.

Severe chest pains, prolonged bleeding and seizures are examples of emergency conditions.

If you have an emergency while outside the Empire BlueCross BlueShield service area, be sure to show your Empire BlueCross BlueShield I.D. card at the emergency facility. If the Hospital participates with another Blue Cross and/or Blue Shield program, your claim will be processed by the local plan (or by the BlueCard Worldwide Program, if it is a participating Hospital outside the United States). If the Hospital does not participate in any BlueCross or BlueShield program, you should submit the claim to Empire BlueCross BlueShield for consideration.

**Maternity Care**

The Plan covers certain services and supplies for maternity and newborn care. Under federal law, the Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Fund may not require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan also covers:

- a home care visit if the mother decides to leave before the 48-hour/96-hour period described above, as long as the mother requests the visit from the Hospital or a home health care agency within the 48-hour/96-hour period;
- the services of a certified nurse/midwife affiliated with a licensed Facility and provided under a Doctor's direction;
- circumcision of newborn males; and

- special care for the baby if the baby stays in the hospital longer than the mother.

**Hospital Care**

The Plan covers all Medically Necessary Hospital services and supplies. In addition to those listed on the chart on pages 34-35, the Plan covers:

- semi-private room and board (if you request a private room when it is not Medically Necessary for you to have one, you will only receive coverage for the average cost of a semi-private room);
- operating and recovery rooms;
- cardiac care unit;
- social, psychological and pastoral services;
- reconstructive surgery associated with injuries unrelated to cosmetic surgery;
- reconstructive surgery for a functional defect that is present from birth; and
- physical, occupational, speech or vision therapy, including Facilities, services, supplies and equipment.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- treatment of physical complications or the mastectomy, including lympedemas.

Such benefits are subject to any Co-Insurance and Deductibles described in the chart on pages 34-35.

**Ambulatory services**

The Plan covers same-day Hospital services such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered if all the following requirements are met:

- services are performed at a same-day or Hospital outpatient surgical facility;
- services require the use of both surgical operating and postoperative recovery rooms;
- services require either a local or general anesthesia;
- Hospital admission is not required but would be in the absence of a same-day surgery center.

Please note that some In-Network Providers may use Out-of-Network radiologists, anesthesiologists or pathologists. Just because are receiving services at a Participating Hospital/Facility, it does not mean that all the services you receive will be provided by In-

Network Providers. Services received in a Participating Hospital/Facility from Out-of-Network Providers will be covered as Out-of-Network Benefits. You should consult with your surgeon and/or Hospital in advance about using In-Network Providers, including radiologists, anesthesiologists and pathologists.

**Surgical services**

When two or more surgical procedures are performed at one time through the same incision, benefits will be limited to the amount payable for the procedure with the greater reimbursement rate. When two or more surgical procedures are performed at one time through separate incisions, benefits will be provided only for the more expensive procedure, plus 50% of the reimbursable rate for all other procedures.

**Pre-surgical testing**

Pre-surgical testing is covered if it is performed no more than seven days prior to the surgery.

**Durable Medical Equipment and Supplies**

The Plan covers the purchase, rental and/or repair of prosthetics, orthotics and other durable medical equipment and supplies. However, the cost of buying any such equipment will be covered only if the purchase price is expected to be less than long-term rental cost, or if the item is not available for rent. In addition, the following restrictions apply:

- Enteral formulas will be covered only if the patient has a written order from a Doctor, stating that the formula is Medically Necessary and effective, and that without it, the patient would become malnourished, suffer from serious physical disorders or die.
- Modified solid food products will be covered for the treatment of certain inherited diseases only if the patient has a written order from a Doctor.
- Orthotics are covered only if Medically Necessary and prescribed by a licensed medical provider.

**Skilled Nursing Facilities**

The Plan covers inpatient care in a Skilled Nursing Facility as long as your Doctor provides the Fund all of the following information prior to your care commencing:

- a referral and written treatment plan;
- your projected length of stay; and
- an explanation of the services you need and the intended course of care.

All care rendered at a Skilled Nursing Facility must be provided under the direct supervision of a Doctor, registered nurse, physical therapist or other health care professional.

**Hospice Care Facilities**

The Plan will cover services rendered at a hospice care facility provided your treating Doctor certifies that you are terminally ill (that is, has a life expectancy of six months or less) and the hospice care is provided by a hospice organization certified pursuant to the certification process required by the state in which the hospice organization is located.

Covered hospice services include:

- up to 12 hours a day of intermittent nursing care by an RN or LPN;
- medical care by the hospice Doctor;
- approved drugs and medications
- physical, occupational, speech and respiratory therapy when required to control symptoms;
- lab tests, x-rays, chemotherapy and radiation therapy;
- counseling services for the patient's family, including bereavement counseling for up to one year following the patient's death;
- Medically Necessary transportation between home and Hospital or hospice;
- medical supplies and rental of durable medical equipment
- up to 14 hours of respite care per week.

To be covered, no hospice services can be separated by more than three consecutive months.

**Home Health Care**

The Plan covers home health care services, provided your Doctor gives the Fund a written treatment plan. You are covered for up to 12 hours of care in one day. Home health care services include:

- part-time nursing care by an RN or LPN;
- part-time home health aid services;
- restorative physical, occupational or speech therapy;
- medications, medical equipment and medical supplies prescribed by a Doctor; and
- laboratory tests

**Physical Therapy**

The Plan covers physical therapy, physical medicine and rehabilitation services, provided the treatment is prescribed by a Doctor and is designed to improve or restore a physical function of the body. In-patient physical therapy will be covered only if confinement is required for another medical condition**.** Out-patient therapy must be performed at the therapist's office or at approved Facility.

**Occupational, Speech or Vision Therapy**

The Plan covers occupational, speech or vision therapy, provided the treatment is prescribed by a Doctor and administered by skilled medical personnel at the patient’s home, in a therapist's office

or in an approved outpatient Facility. All services must be performed by a licensed speech/language pathologist or audiologist.

**Autism Therapy**

The Plan will provide coverage for the following services for autism spectrum disorder when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder:

- **Screening and Diagnosis**. Coverage will be provided for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- **Assistive Communication Devices**. Coverage will be provided for a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, coverage may be provided for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage will also be provided for software and for applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Plan will determine whether the device should be purchased or rented.

  Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, coverage will be provided for one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for delivery or service charges or for routine maintenance or the additional cost of equipment or accessories that are not Medically Necessary.

- **Behavioral Health Treatment**. Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual will be covered when provided by a licensed provider. Coverage for applied behavior analysis will also be covered when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program

must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

- **Psychiatric and Psychological Care**. Coverage will be provided for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

- **Therapeutic Care**. Coverage will be provided for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers arc otherwise covered under the Benefit Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under the Benefit Plan.

The Plan will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under New York State Education Law. You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under the Plan for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this section. Any Deductible, Copayment, or Coinsurance that applies to physician medical services; specialist office visits will apply to assistive communication devices covered under this section.

For purposes of this section "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder, Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

**Mental Health Care**

The Fund covers mental health treatment on both an inpatient and outpatient basis to the same extent it covers inpatient and outpatient medical care. This means that the same financial terms and treatment limitations that apply to medical care will also apply to mental health and substance abuse care.

In addition to using In-Network and Out-of-Network Providers, you may obtain certain mental health counseling through the Plan's Employee Assistance Program administrator, Lower Hudson Valley EAP. If you are interested in using this service, please call 1-800-327-2799 to find out about options available to you.

**Organ and Tissue Transplants**

The Plan covers organ and tissue transplant services received during a Transplant Benefit Period. A Transplant Benefit Period begins five days before the date of an organ or tissue transplant and ends eighteen months after the transplant has occurred. In order to be eligible for transplant benefits, the patient must obtain written opinions from two Board-certified Specialists in the applicable field of surgery, certifying that alternative methods of treatment would not be effective in treating the patient's condition. All transplants must be performed at a major medical center approved by the federal government or by the appropriate state agency in the state where the center is located.

Provided the other requirements are met, the Fund will cover the following organ and tissue transplants:

- bone marrow;
- kidney;
- heart;
- heart and lung;
- liver;
- lung;
- pancreas

The Fund will cover the following transplant-related services and supplies:

- organ and tissue procurement, including the removal, preservation and transportation of the donated organ/tissue;
- transportation of the patient and a companion to and from the transplant facility (if the person receiving the transplant is a minor or mentally handicapped, the Fund will cover the transportation of two companions);
- reasonable and necessary food and lodging costs incurred by the patient and travel companion(s). Itemized receipts must be submitted to the Fund;
- Room and board at the transplant Facility;
- Doctor services, including diagnosis, treatment and surgery;
- A private duty RN or LPN, if provided on an outpatient basis;
- durable medical equipment;
- diagnostic and radiologic services;
- approved immunosuppressant drugs;
- rehabilitative therapy for conditions directly related to the transplant; and
- surgical supplies and dressings, anesthesia and its administration, and operating room fees.

If the patient requires two or more transplants during his lifetime, coverage will be provided as follows:

- if the transplants result from unrelated causes, they will be treated as separate Transplant Benefit Periods;

- if the transplants result from related causes, they will be treated as separate Transplant Benefit Periods if:
    - the patient returns to active work between the two Transplant Benefit Periods for at least one week; or
    - in the case of a non-working Dependent, the Transplant Benefit Periods are separated by at least three months.
- if the transplants result from related causes and are not separated by the periods described above, they will be treated as one Transplant Benefit Period.

If the patient is in his Transplant Benefit Period at a time when coverage under the Plan terminates and his maximum organ and tissue transplant benefits have not been exhausted, coverage for organ and tissue transplant benefits only will continue until the earlier of: (i) the date on which the Transplant Benefit Period ends; or (ii) the date on which the maximum benefits have been exhausted.

# Ineligible Medical and Hospital Expenses

In addition to the general exclusions beginning on page 28, the following expenses are not covered under the Plan's Medical or Hospital Benefits. However, some of these services may be covered under other Sections of the Plan.

- government hospital services, except specific services covered in a special agreement between Empire BlueCross BlueShield and a governmental hospital or services in a United States Veteran's Administration or Department of Defense Hospital for conditions not related to military service. In an emergency, coverage will be provided until the government hospital can safely transfer the patient to a participating hospital;
- cosmetic treatment, except for breast construction as described on page 39, and except for treatment that is necessary to ameliorate a disfiguring disease or a deformity arising from or directly related to a congenital abnormality. For this purpose, cosmetic treatment includes any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease
- routine examinations and checkups that exceed the maximum coverage period;
- dental treatment, except treatment of sound natural teeth injured in an accident, provided treatment is rendered within 12 months of the date of injury. (However, these services may be covered under the Dental Benefits);
- expenses for the diagnosis or treatment of infertility, including artificial insemination and in-vitro fertilization, gamete and zygote intrafallopian tube transfer and intracytoplasmic sperm injection
- treatment or care for Temporomandibular Joint (TMJ) Syndrome (except may be covered under the dental benefit)
- services performed at home, except for those services specifically allowed under the provisions of this SPD;
- prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication, unless covered under the Fund's prescription drug benefit or preventive care benefits;

- reversal of sterilization;
- travel expenses, except as otherwise specified;
- services such as laboratory, x-ray and imaging, and pharmacy services as required by law from a Facility in which the referring Doctor or his/her immediate family member has a financial interest or relationship;
- the following specific preventive care services:
    - screening tests done at your place of work at no cost to you;
    - free screening services offered by a government health department;
    - tests done by a mobile screening unit, unless a Doctor not affiliated with the mobile unit prescribes the tests;
- the following specific emergency services:
    - use of the emergency room to treat routine ailments because you have no regular Doctor or because it is late at night (and the need for treatment is not sudden and serious);
    - ambulette;
- the following specific maternity care services:
    - days in hospital that are not Medically Necessary (beyond the 48 hour/96 hour limits);
    - private room, except that the Plan will pay the reasonable and customary charges of a semi-private room. In addition, if there are only private rooms available at the time of your admission, the Fund will cover the private room rate.
    - private duty nursing
- the following specific equipment:
    - air conditioners or purifiers;
    - humidifiers or de-humidifiers;
    - exercise equipment;
    - swimming pools;
    - hot tubs or saunas;
    - massage or inversion tables;
    - central air systems;
- Skilled Nursing Facility care that primarily:
    - gives assistance with daily living activities;
    - is for rest or for the aged;
    - is convalescent care;
    - is sanitarium-type care;
    - is a rest cure;
- the following specific home health care services:
    - custodial services, including bathing, feeding, changing or other services that do not require skilled care;
    - Out-Of-Network home infusion therapy
- the following specific physical, occupational, speech or vision therapy services:
    - 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.

# Prescription Drug Benefits

The Fund offers prescription drug benefits through a self-insured arrangement with Express Scripts. The list of prescription drugs that are covered by the Plan is known as a "formulary." The Plan's formulary includes a wide selection of generic and brand-name medications. You can get a copy of the applicable formulary by contacting Express Scripts at 1-800-849-9036.

There are two ways to fill prescriptions:

**At Participating Retail Pharmacies**

To have your prescription filled at a retail pharmacy, go to a pharmacy that participates in the Express Scripts retail network with your prescription and your prescription ID card. All prescriptions filled at a participating retail pharmacy can be written to provide for up to a 34-day supply.

Your Co-payment is:

- $9 if the prescription or refill is filled with generic drugs,
- 20% coinsurance if it is filled with brand-name drugs;
- 20% coinsurance if it is filled with specialty drugs through Accredo.

You are not required to satisfy any deductible and there are no claim forms to complete. If your doctor prescribes a formulary brand-name drug, your prescription will be filled with an "A" rated generic drug unless a generic form is not available or your doctor writes "DAW" (dispense as written) on your prescription. A generic drug has the identical chemical composition of a brand-name drug.

Coinsurance is a percentage of the drug's cost. To check the cost for any of your covered drugs, log in at express-scripts.com and choose "Price a medication" from the menu under "Manage Prescriptions." You can also call Accredo, an Express Scripts specialty pharmacy, at 1-800-803-2523 for questions about specialty drug costs or to order a specialty drug.

If you fill your prescription at a pharmacy that does not participate in the Express Scripts network, you will be required pay the entire cost of your prescription drug. You may then submit a written request to Express Scripts for reimbursement or call them at 1-800-849-9036. If your prescription is for a drug that is covered under the Plan, Express Scripts will reimburse you for the Plan's discounted rate less any applicable copay.

You will pay more for your long-term maintenance drugs (such as those used to treat high blood pressure or high cholesterol) unless you order your prescriptions through the mail by using the Express Scripts Pharmacy. The first three times that you purchase a long-term maintenance drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay the entire cost if you continue to fill your prescription for maintenance drugs at retail. To avoid paying more, use the Express Scripts Pharmacy and pay your mail- order co-payment for up to a 90-day supply.

**Using the Mail Order Pharmacy**

The Express Scripts mail order program is designed for those who take maintenance drugs (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma). For up to a 90-day supply of a covered medication, participants pay a Co-payment of:

- $22.50 if the prescription or refill is filled with generic drugs;
- 20% coinsurance if it is filled with brand-name drugs;
- 20% coinsurance if it is filled with specialty drugs through Accredo.

There are two ways to submit mail-order prescriptions through the Express Scripts Pharmacy:

By mail –

- Ask your doctor to write a prescription for up to a 90-day supply, plus refills for one year, as appropriate. (If you need a supply of the medication while you wait for your mail order to arrive, ask the doctor for 2 two prescriptions: one for a 30-day supply to be filled at a participating retail pharmacy, and the other for up to a 90-day supply to send to the Express Scripts Pharmacy.)

- Mail the prescription, a completed mail-order form, and your payment to the Express Scripts Pharmacy at the address on the form. Be sure to fill in all areas of the form, including the member ID number shown on your prescription drug card.

By fax –

- Ask your doctor to call 1-888-327-9791 for instructions on faxing the prescription to the Express Scripts Pharmacy. Provide him or her with your member ID number, which is needed to complete the transaction. (Only doctors can fax prescriptions to Express Scripts.)

You can pay by e-check, credit card, check, or money order. Standard shipping is free. Expedited shipping is available for an extra charge. Orders usually ship within 8 days after Express Scripts receives your prescription.

To obtain extra order forms, physician fax forms, or return envelopes, visit www.expressscripts.com and click "Forms & Cards" under "Prescriptions & Benefits" on the left side of the screen. You can also order forms and envelopes by calling Express Scripts Member Services at 1-800-849-9036. (If you're a first-time visitor to the Express Scripts website, please take a moment to register using your member ID number and a recent prescription number.)

**Please note:** Certain drugs that are included in the preventive care recommendations from the U.S. Preventive Services Task Force with a rating of A or B are covered by the Fund with no cost-sharing (co-pay). In addition, drugs included in the comprehensive guidelines on preventive

care for women supported by the Health resources and Services Administration will also be available with no out of pocket expenses. However, for both these changes, drugs will be paid with no cost-sharing only to the extent required by law and subject to certain age, gender, and other reasonable medical management limitations. For example, oral contraceptives in generic form will be covered at no cost to you, but if you choose a brand name contraceptive for which a generic form is available, you will still have to pay the applicable Plan coinsurance for brand drugs, unless it is medically inappropriate for you to take the generic form. If you have questions about whether you are eligible to receive certain prescription drugs without any co-payment, please call Express Scripts at 1-800-849-9036.

**Eligible Drugs**

The following drugs are covered under the Plan:

- federal legend prescription drugs;
- drugs requiring a prescription under the applicable state law
- oral contraceptives for participant and spouse, and dependent children to the extent required by law;
- vitamins with a prescription or to the extent required by law;
- pre-natal vitamins requiring a prescription;
- diabetic test strips.
- Aspirin, fluoride, folic acid, and iron, with a prescription subject to certain age, gender, and other reasonable medical management limitations permitted by law. You should contact Express Scripts to inquire about any limitations that apply.
- Food and Drug administration approved contraceptive methods, including some that are generally available over the counter, will be covered for female participants and dependents with reproductive capacity, with a valid prescription, to the extent required by law. Contraception for men is not covered.

**Ineligible Drugs**

The following drugs are not covered under the Plan:

- drugs that are not Medically Necessary;
- non-legend drugs;
- therapeutic devices or appliances, support garments and other non-medical substances;
- drugs intended for use in a Doctor's office or another setting other than home use;
- investigational or Experimental drugs, including compounded medications for non-FDA approved use;
- prescriptions that a covered person is entitled to receive without charge under any workers' compensation law, or any municipal, state, or federal program;
- dietary supplements;
- fertility medications;
- anorexiants;
- Retin-A (age 26 and over);
- growth hormones (unless prior authorization from the Fund is obtained);
- substance abuse agents limited by federal laws governing controlled substances.

**Pre-Authorization for Specialty Drugs**

Certain specialty drugs require pre-authorization from Accredo Specialty Pharmacy before the Fund will provide coverage. You will receive additional correspondence from Accredo about the pre-authorization process and a list of specialty drugs for which pre-authorization is required. Once you receive a prescription for a specialty drug, you should contact Accredo immediately at 1-800-803-2523. Accredo will review your medical history and consult with the prescribing doctor to ensure that the drug being prescribed in appropriate for your medical condition. In some cases, after consulting with your doctor, Accredo may authorize a preferred specialty drug as an alternative to a prescribed non-preferred specialty drug. However, Accredo will never change the prescription without the approval of the prescribing doctor. Once the drug has been pre-authorized, it will be covered by the Fund consistent with the terms of this SPD. If Accredo does not pre-authorize the drug, the Fund will not provide coverage. You have the right to appeal a pre-authorization denial consistent with the Fund's claims and appeals procedures.

If you fail to seek pre-authorization for a drug before you submit the prescription to the pharmacy, the pharmacist will advise you that you need to contact Accredo for pre-approval before coverage under the Plan is available.

# Employee Assistance Program

The Plan provides coverage for the treatment of alcohol and substance abuse, mental health issues, anxiety/depression, marital problems, anger management and job stress. To use this benefit, contact Lower Hudson Valley Employee Assistance Program by calling 1-800-327-2799. Its staff of professionals will help identify and evaluate your situation and direct you to the appropriate services.

If you require substance abuse treatment, Lower Hudson Valley EAP can help you find inpatient or outpatient treatment in your area, however, you are not required to contact Lower Hudson Valley EAP for pre-approval prior to obtaining treatment. The Fund will pay all Medically Necessary inpatient or outpatient substance abuse treatment expenses at any facility you choose.

**Eligible Expenses**

The maximum amount the Fund will cover is $50 per visit. The reasonable charges of a properly-licensed Certified Social Workers and/or Certified Alcohol Counselors may be included toward the $50 limit.

**Ineligible Expenses**

In addition, to the general exclusions, the Fund will not cover:

- services that are related to the commission of a criminal act.

# Dental Benefits

You and your eligible Dependents have the option to purchase a dental HMO or dental PPO plan insured by Cigna. The terms and conditions of coverage are explained in the insurance booklet issued by Cigna. A copy of this booklet will be provided to you. If you elect to enroll in this coverage, the premiums will be deducted from your Supplemental HRA. Of you do not have a sufficient balance in your Supplemental HRA to cover the cost of the premiums, you can self-pay the monthly premiums directly to the Fund office for a maximum of 12 consecutive months. Your self-pay premiums are due on the first day of the month for which dental coverage is sought. If the Fund does not receive your premiums by the 5th day of each month, your dental coverage will terminate retroactive to the first day of that month.

The Trustees have the right to change premiums at any time. Please contact the Fund Office for the current premiums.

# Vision Care Benefits

The Plan covers the following eligible vision care expenses:

- One complete eye exam per Plan Year performed by a legally qualified and licensed ophthalmologist or optometrist that participates in the Davis Vision network, subject to a $20 co-payment;

- One pair of prescribed eyeglass per Plan Year, subject to a $20 co-payment, or one set of contact lenses per Plan Year. A set of contact lenses means 4 boxes of disposable lenses or 2 boxes of planned replacement lenses.

There are additional charges and limits that apply to non-collection or designer eyeglasses or contact lenses, as well as for certain lens enhancements. If you have any questions about your expected out-of-pocket costs, please contact Davis Vision at 1-800-999-5431 or www.davisvision.com.

# Disability Income Benefits

The Plan's Disability Income Benefit gives you and your family some financial protection in the event you are absent from work because of an illness or injury. If you are totally disabled and unable to work in employment covered by the Plan, the Plan will pay you a weekly disability benefit of $140.00. This benefit is taxable to the recipient. In order to be eligible to receive this benefit, you must be receiving state disability benefits or benefits under Workers Compensation and submit proof to the Fund Office of your receipt of these State benefits. Benefits will be paid retroactive to the date of your illness or injury once sufficient proof has been received by the Fund Office.

Disability Benefits will continue for a maximum 26 weeks for each disability period. The 26-week maximum applies to any one period of disability, regardless of whether there is more than one

cause for your disability or whether you suffer from successive disabilities. A successive disability will constitute a new period of disability if:

- you return to work between periods of disability and your disabilities result from unrelated causes; or
- you return to work for six consecutive months between periods of disability resulting from the same or related causes.

# Life Insurance Benefits

Your life insurance benefits are insured by Dearborn National Life Insurance Company of New York ("Dearborn"). Detailed information about this benefit, including filing claims and appeals, is provided in the booklet prepared by Dearborn. If you need another copy of this booklet or have questions about your coverage, please contact Dearborn. The information noted below is only a summary of your benefits. If there is any conflict between these provisions and the Dearborn booklet, the terms of the Dearborn booklet will govern.

Life Insurance benefits are payable to your beneficiary if you die while coverage is in effect. If you are eligible for coverage, your beneficiary will receive $30,000 upon your death, subject to the terms of the policy. Your beneficiary is the person or persons you designate in writing on a form that is kept on file at the Fund Office. You may change your designated beneficiary at any time by completing and submitting a revised form to the Fund Office. A designation or change of beneficiary received at the Fund Office after your death will not be honored. If there is no living designated beneficiary when you die, your Life Insurance benefit will be paid consistent with the terms of the Dearborn booklet. You may also be eligible to purchase a conversion policy under certain circumstances that are described in the Dearborn booklet.

# Supplemental Health Reimbursement Account

The Supplemental Health Reimbursement Account provides reimbursement for Eligible Medical Expenses incurred by participants who work in Nassau, Suffolk, Westchester, Hudson Valley and Rockland counties and their eligible dependents. Contributions will be made on your behalf to a Supplemental Health Reimbursement Account by your employer consistent with the terms of your collective bargaining agreement or written participation agreement with the Fund. However, in order for contributions received on your behalf to be credited to the Supplemental Health Reimbursement Account, you (the employee) must be enrolled in either the Fund's uninsured medical plan described in this SPD, or in another group health plan (e.g., through your spouse's employer) with coverage that meets the minimum value standards of the Affordable Care Act ("ACA").

**Please note:** Medical coverage purchased through a State Health Plan Marketplace is not considered a group health plan and if you are enrolled in a State Marketplace health plan only, no contributions received on your behalf will be credited to the Supplemental Health Reimbursement Account until you enroll in the Fund's uninsured health plan or in another group health plan with coverage that meets the minimum value standards of the ACA. If do not enroll in such coverage by the January 1 that is at least 36 months after the date on which contributions

were received on your behalf, any such contributions will be permanently forfeited and will not be reinstated, even if you subsequently enroll in group health coverage that meets the minimum value standard of the ACA.

**New Participants**

For new employees, once contributions are first received by the Fund on your behalf, you will become a participant in the Plan. Once the Fund has received $1,000 in contributions on your behalf, you will receive an Enrollment Application ("Health Insurance Application") to enroll yourself and your eligible Dependents. You will be required to complete a certification to inform the Fund of any health coverage you have. If you are not enrolled in an employer-sponsored group health plan with coverage that meets the minimum value standards of the ACA, contributions received on your behalf will not be credited to the Supplemental Health Reimbursement Account until you are enrolled in the Fund's uninsured medical plan or you enroll in another employer-sponsored group health plan with coverage that meets the minimum value standards of the ACA and inform the Fund of such coverage.

**Certification of Other Coverage If Not Enrolled in the Fund's Health Coverage**

Each January 1 and/or July 1 that you are not enrolled in the Fund's self-insured medical plan, the Fund will send you a certification to certify that you are enrolled in an employer-sponsored group health plan with coverage that meets the minimum value standard of the ACA. It is important that you complete this form and return it to the Fund Office within 30 days of receipt. If you are not enrolled in an employer-sponsored group health plan with coverage that meets the minimum value standards of the ACA or if you fail to timely return the completed certification to the Fund Office and you preform work in Covered Employment, any contributions received by the Fund on your behalf for such work will not be credited to the Supplemental Health Reimbursement Account on your behalf until you enroll in a group health plan with coverage that meets the minimum value standard of the ACA, subject to the forfeiture rules described in this SPD.

**Using Your Supplemental Health Reimbursement Account After Your Health Coverage Ends**

If your group health coverage (either with Fund or another group health plan that meets the minimum value standards of the ACA) ends, you and your eligible dependents may continue to receive reimbursements for Eligible Medical Expenses using the balance in your Supplemental Health Reimbursement Account as of the date your group health coverage terminates. However, any contributions received on your behalf after the termination of your group health coverage will not be credited to the Supplemental Health Reimbursement Account until you are re-enrolled in either the Fund's uninsured medical plan or in another employer-sponsored group health plan with coverage that meets the minimum value standards of the ACA. If you do not enroll in such coverage by the January 1 or July 1 that is at least 36 months after the date on which contributions were received on your behalf, any such contributions will be permanently forfeited and will not be reinstated, even if you subsequently enroll in group health coverage that meets the minimum value standard of the ACA.

**Forfeiture of Supplemental Health Reimbursement Account**

Any participant who has a Supplemental Health Reimbursement Account balance with the Fund can elect to permanently waive and forfeit that balance and all future contributions made to the Supplemental Health Reimbursement Account each year during the month of December, and upon the loss of health coverage with the Fund, by completing a Forfeiture Form. If you complete the Forfeiture Form during the month of December, your waiver will take effect January 1 of the next year. In addition, you will have the right to permanently forfeit your Supplemental Health Reimbursement Account balance within 60 days of the date on which your coverage with the Fund terminates. You can request a Forfeiture Form by contacting the Fund Office. Once you complete the Forfeiture Form, any balance remaining in your Supplemental Health Reimbursement Account will be forfeited to the Fund and you cannot get that money back.

**Eligible Medical Expenses**

Eligible Medical Expenses are defined as expenses that are tax deductible under Section 213 of the Internal Revenue Code for which you have not otherwise been reimbursed from insurance or from some other source. To be considered an Eligible Medical Expense, the expense must be included in Appendix A of this SPD, as amended from time to time, and satisfy the other requirements of this SPD.

To be considered an Eligible Medical Expense, the expense cannot otherwise be reimbursed under this Plan, from insurance or from some other source, such as an employer sponsored flexible spending account. In addition, unless specified otherwise in Appendix A, an expense is not an Eligible Medical Expense if it is otherwise excluded from coverage under the terms of this Plan. The Fund will not reimburse any expenses that are not medically necessary, including but not limited to, services that are experimental or cosmetic.

The Fund has a right in its sole discretion to determine whether an expense is eligible for reimbursement from your Supplemental Health Reimbursement Account. A determination as to whether an expense is reimbursable will not be made until you have already paid for the supplies and/or services. As noted in Appendix A, certain expenses (e.g., durable medical equipment) require both a physician's prescription and a letter of medical necessity. The prescription must indicate the specific medical condition that the durable medical equipment is intended to treat. The letter of medical necessity must explain why the durable medical equipment is necessary and indicate the anticipated medical outcome. A letter of medical necessity is considered valid for 12 months from the date it is written by a physician. No Participant or Dependent can elect to receive cash or other taxable or non-taxable benefit from their Supplemental Health Reimbursement Account other than for the reimbursement of Eligible Medical Expenses.

**No Ownership Interest**

You have no ownership interest in your Supplemental Health Reimbursement Account. Under federal law, you are not entitled to receive any money from your Supplemental HRA except for payment of post-tax premiums or reimbursement of Eligible Medical Expenses as approved by

the Fund. The Fund has a right to deny your request for reimbursement from your Supplemental Health Reimbursement Account if the submitted expense is not permitted under the Plan.

**Claims Filing Deadline**

To be eligible for reimbursement, a claim must be received by the Fund Office within 12 months of the date on which the expense was incurred. If a claim is received after the expiration of this 12 month period, your request for reimbursement will be denied. The minimum allowable reimbursement is $100. Therefore, expenses should not be submitted until, when added together, they total at least $100. However, each January and July you may seek reimbursement of Eligible Medical Expenses that are less than $100. In addition, you are limited to one submission of claims for each calendar month. However, you can submit as many claims as you want with each submission. For example, if you submit 6 claims for Eligible Medical Expenses on March 5, 2017, you are not entitled to submit claims again until April 1, 2017. If you submit a claim on March 21, 2017 instead of waiting until April 1, 2017, your claim will be denied as ineligible for reimbursement at that time. For all purposes, a claim is considered submitted to the Fund on the date it is received in the Fund Office.

Under no circumstances can you receive reimbursement for expenses that were incurred before the date you became a Participant in the Plan. All claims must be submitted in writing and include substantiation satisfactory to the Fund, that the expenses have been incurred and paid by you or your Dependent, and the amount of the charge. You must also confirm that the expenses have not been reimbursed and are not reimbursable under any other medical plan that provides health coverage. For doctor or hospital expenses or medical supplies, you must submit a statement from your insurance company (Explanation of Benefits) showing the expenses incurred and that the balance owed has been paid in full. Please review Appendix A to determine exactly what documentation you are required to submit for each type of claim. If you are required to submit a receipt, such as from a doctor or pharmacy, you must submit the original receipt or a clearly legible photocopy. The Fund reserves the right to request the original receipt. In addition, the Fund will not return any documents to you. You should make copies for your records. Payments will generally be made directly to you, not to providers or suppliers. However, you may request the Fund to pay the provider directly if the amount owed to the provider is over $600 and you submit an Assignment of Benefits Form (available from the Fund Office) and an IRS W-9 Form signed by the provider.

**Balance in Your Supplemental Health Reimbursement Account after Your Death**

If you die and you have a balance remaining in your Supplemental Health Reimbursement Account, your Dependents can continue to submit claims for reimbursement from your Supplemental Health Reimbursement Account. Any balance in your Supplemental Health Reimbursement Account will be forfeited following 36 consecutive months of no activity (no activity means that no Employer contributions have been made to your account and no amounts have been deducted from your account to pay premiums or claims for Eligible Medical Expenses). Forfeiture will occur on the last day of the 36$^{th}$ month and will be used for Fund administrative expenses. Balances will not be reinstated, even if your Employer again makes contributions to the Fund on your behalf at a later date**.** It is your responsibility to monitor the activity in your

Supplemental Health Reimbursement Account. The Fund Office is not required to provide notice prior to any forfeiture.

**Investment Gains or Losses**

The Trustees reserve the right to adjust Supplemental Health Reimbursement Account balances to reflect investment gains or losses incurred by the Fund. If the Trustees determine, in their sole discretion, that the Fund's investment performance during any period warrants, they may increase or decrease Supplemental Health Reimbursement Account balances to reflect such performance.

**Administrative Fees**

In addition, if there have been no contributions to, or withdrawals from, your Supplemental Health Reimbursement Account for 12 consecutive months beginning each July 1, the Fund will automatically deduct an annual administrative fee of $120 from your HRA on the following June 30 of each year, until the earlier of:

- The date on which your Supplemental Health Reimbursement Account is forfeited;
- The date on which there is no money remaining in your Supplemental Health Reimbursement Account; or
- The date on which your Employer begins making contributions again on your behalf.

Amounts deducted from contributions made to the Fund on your behalf or amounts deducted as an annual administrative fee will not be refunded to you even if contributions later recommence. The Fund's Board of Trustees reserves the right to change these amounts at any time.

**Required Balance**

You must maintain a balance of at least $1,000 in your Supplemental Health Reimbursement Account at all times. Once your account balance goes below $1,000, you will not be eligible for any additional reimbursements from your Supplemental Health Reimbursement Account until your account balance exceeds $1,000, except for the payment of COBRA or self-pay or other health insurance premiums. For example, assume your account balance is $1,250 and you properly submit a request for the reimbursement of Eligible Medical Expenses that total $550. You will receive only $250 in reimbursements and the remainder of your claim will be denied. You can resubmit these denied claims for reimbursement once your account balance exceeds $1,000, provided the other requirements for reimbursement are satisfied.

Retirees are not required to maintain a $1,000 balance in their Supplemental Health Reimbursement Account. Retirees can continue to receive reimbursements from their Supplemental Health Reimbursement Account until there is no balance remaining, subject to the other rules in the SPD. The forfeiture rules described in this section also do not apply to retirees.

**Suspension of Supplemental Health Reimbursement Account**

As described above on page 15, your Supplemental Health Reimbursement Account will be suspended if you work in Disqualifying Employment.

# Vacation Benefits

These benefits are available to Participants if they are provided for in the applicable collective bargaining agreement with the Union. Your Employer is required to make contributions to the Fund for vacation benefits only if such contributions are required by the terms of their collective bargaining agreement with the Union or other written agreement between the Employer and the Fund. All such contributions are made on a post-tax basis and are deducted from your wages. You will be credited with all required vacation contributions received by the Fund on your behalf. You will not receive vacation benefits for any contributions made on the basis of your self-employment.

**Distribution of Vacation Benefits**

There are two vacation benefit periods- January 1 through June 30 and July 1 through December 31. Each February and August, the Fund will provide eligible Participants with payment of all amounts contributed on their behalf during the prior vacation benefit period. For example, if your employer contributed $4,500 on your behalf between January 1, 2017 and June 30, 2017, then in August 2017, you will receive payment of $4,500. The Fund may also process late employer contributions at other times. The Fund will generally pay vacation benefits only to a Participant, or a Beneficiary if the Participant is deceased. However, if the Fund is served with a third party lien, judgment, order, garnishment, execution or other legal notice which requires payment to a third party, the Fund Office will use the Participant's vacation benefits to satisfy such obligation before paying the remaining benefits, if any, to the Participant or Beneficiary.

**Administrative Fee**

The Board of Trustees may, in its sole discretion, impose an administrative service fee for any vacation benefit period, which will be deducted from each Participant's payment.

**Forfeiture of Vacation Benefit**

If no contributions have been made on a Participant's behalf for 60 consecutive months and the Trustees have been unable to locate such Participant after a diligent search, the Participant's accumulated vacation benefits will be forfeited back to the Fund, provided that if the Participant contacts the Fund Office at a later date, he will receive full payment of the forfeited amount.

**Designation of Beneficiary**

Every Participant must designate a Beneficiary to receive vacation benefits from the Fund in the event of his death. If you are married, your Beneficiary is automatically your spouse, unless your spouse consents to an alternate beneficiary. If the Participant marries after he has designated a Beneficiary, such designation will automatically be void unless the spouse consents to such

designation. All Beneficiary designations must be made on a form that will be provided to you by the Fund Office and will not be effective until it is received by the Fund Office. No changes in Beneficiary received by the Fund after the Participant's death will be effective. If the Participant is not married at the time of this death and has not designated a Beneficiary, benefits will be paid to the Participant's children, per stirpes. If there are no surviving children, then benefits are paid to the Participant's surviving parents, or if none, then to the Participant's estate. If the Beneficiary is a minor, amounts due to such Beneficiary shall be paid to the person who is providing care to the minor for the use of such minor.

# Subrogation and Reimbursement

If you or your Dependents are injured as a result of negligence or other wrongful acts and you and/or your Dependents apply to the Fund for benefits and receive such benefits, the Fund shall have a first priority lien for the full amount of those benefits against any recovery you receive from any third party that caused, contributed to, or aggravated your injuries or from any other source responsible for payment thereof related to such an accident. This is referred to the Fund's right of reimbursement and subrogation.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay your (or your eligible dependent's) benefits based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. The Fund advances benefits to you and your dependents only as a service to you. You must reimburse the Fund if you obtain any recovery from another person or entity.

You and/or your dependent are required to notify the Fund within ten days of any accident or Injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit or settlement negotiations arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.

If you or your dependent receive any benefit payments from the Fund for any Injury or Sickness, and you or your dependent recover any amount from any third party or parties in connection with such Injury or Sickness, you or your dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your dependent's behalf in connection with such Injury or Sickness.

Also, if you or your dependent receive any benefit payments from the Fund for any Injury or Sickness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Sickness in your or your dependent's name and also has a right to intervene in any such

action brought by you or your dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Sickness, and regardless of whether you and/or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's right of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the Injury and Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under insured motorist insurance, or any medical pay or no fault benefits payable. The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this section, if you or your dependent submit claims for or receive any benefit payments from the Fund for an Injury or Sickness that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement must also be executed by your or your dependent's attorney, if applicable. Alternatively, if you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) fail or refuse to execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your dependent recovers from a third party.

Any refusal by you or your dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery your receive, no matter how characterized, up to the full amount paid by the Fund on your or your dependent's behalf relating to the applicable Accident or Injury will be

considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident or Injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your eligible dependent chooses not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your dependent waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or your dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for your or your dependent's injuries.

# Fraud

The Board of Trustees reserves the right to cancel or rescind Fund coverage for any Participant or Dependent who willfully and knowingly engages in any activity intended to defraud the Plan. If a claim has been submitted for payment or paid by the Fund as a result of fraudulent representations, such as enrolling a dependent who is not eligible for coverage or continuing coverage for a spouse after a divorce or legal separation, the Fund will seek reimbursement and may elect to pursue the matter by pressing criminal charges.

The Fund must be advised of any discounts or price adjustments made to you by any Provider. A Provider who waives or refunds a Co-payment is entering into a discount arrangement with you. The Fund calculates benefit payments based on the amount actually charged, less any discounts, rebates, waiver or refunds of Co-payments or Deductibles. Failure to notify the Fund of such Provider adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan.

Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependent status or accepting benefits in excess of what is covered under the Plan, will be considered fraud.

# Overpayments

If the Fund pays benefits in error, such as when the Fund pays you or your dependent more benefits than you are entitled to, or if the Fund advances benefits that you or your dependent are required to reimburse because, for example, you have received a third party recovery (see the Subrogation Section of this SPD), you are required to reimburse the Fund in full and the Fund shall be entitled to recover such benefits.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund

exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your dependent to reimburse the Fund for an overpaid amount will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by methods which include, but are not necessarily limited to deducting the amount owed from your Supplemental HRA or offsetting the amounts paid against your and/or your dependents' future benefit payments under the Plan. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you and your dependents. If the overpayment or advancement was made to your dependent, the Fund may offset the future benefits payable by the Fund to you and your dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

# Incompetence

In the event it is determined by the Fund's Board of Trustees that someone who is entitled to benefits is unable to care for his affairs because of illness, accident or incapacity, either mental or physical, any payment due may, unless the claim has been made by a duly appointed guardian, committee or other legal representative, be paid to the individual's spouse or such other having care and custody of the claimant or such person having the claimant's power of attorney, as the Board of Trustees will determine in its sole discretion.

# Cooperation

Every claimant is required furnish to the Board of Trustees all such information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Fund.

Failure on the part of the claimant to comply with such requests promptly and in good faith may delay the payment of benefits. The Board of Trustees will be the sole judge of the standard of proof required in any case, and may from time to time adopt such formula, methods and procedures as the Board considers advisable.

# Mailing Address

In the event that a claimant fails to inform the Board of Trustees of a change of address and the Board is therefore unable to communicate with the claimant at the address last recorded and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

# Claims and Appeals Procedures

This Section describes the procedures for filings claims for Plan benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part, and if you wish to appeal this decision to deny a claim.

**Claims For Benefits**

A claim for benefits is a request for Plan benefits that is made in accordance with the Plan's claims procedures. All claims must be submitted in the format prescribed by the Board of Trustees. You are encouraged to submit your claims as soon as possible to avoid missing the claims deadline, which is one year after the date the expense was incurred, unless otherwise noted in the SPD. Any claims that are not submitted within this one-year period will be denied as untimely. A claim will be considered to be filed on the date it is received by the proper recipient.

**How to File Claims**

No claim form is required for most In-Network medical services. When you visit a Network Provider, you pay the cost-sharing amount directly to the Provider.

All claims must be submitted as follows:

In-Network Medical Claims
Empire BlueCross/Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10018

Medical Claims for Participants Eligible for Medicare
Northeast Carpenters Health Fund
91 Fieldcrest Avenue
Edison, NJ 08818
Attn: Medicare

Out-of-Network Medical Claims
Lifetime Benefit Solutions
P.O. Box 780
Liverpool, NY 13088-0780

Prescription Drug Claims
Express Scripts
P.O. Box 14711
Lexington, KY 40512

Employee Assistance Program
Lower Hudson Valley EAP
3505 Hill Blvd. Suite. A,
Yorktown Heights, NY 10598

Life Insurance
Dearborn National Life Insurance Co. of New York
Dearborn National NY
1020 31st Street
Downers Grove, IL 60515-5591

Disability Income and Supplemental HRA Claims
Northeast Carpenters Health Fund
270 Motor Parkway
Hauppauge, NY 11788

The following are not considered claims for benefits:

- Inquiries about Plan provisions or eligibility rules that are unrelated to any specific benefits claims;
- A request for prior approval of a benefit that does not require prior approval by the Fund.

For information about submitting dental claims on appealing a denial of a dental claim, please review the CIGNA booklet.

Vision claims will be handled by your provider at the time of service.

**Claim Forms**

All claim forms must be properly completed and include the following information to be considered a valid claim:

- Participant name;
- Patient name;
- Patient Date of Birth;

- Social Security Number of Participant;
- Date of Service;
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition**,** as maintained and distributed by the American Medical Association);
- ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of Units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address of the prior order;
- Details of any accident that may have caused your injuries and signed subrogation agreement;
- Information about any other coverage that the patient has.

**Authorized Representatives**

You may appoint an authorized representative to take action on your behalf, such as completing claims forms. To do so, you must notify the appropriate claims-processing entity and the Fund Office in writing of the representative's name, address, and telephone number and authorize the release of information (which may include medical information) to your representative. You may be required to provide additional information to verify that your representative 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 without you having to complete an authorization form.

**Reviewing Claims**

In making decisions on claims and appeals, the appropriate claims-processing entity will apply the terms of the Plan document and any applicable guidelines, rules and schedules. The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

**Pre-Service Claims**

A Pre-Service Claim is any claim for benefits under the Plan, the receipt of which is conditioned, in whole or in part, on the approval of the benefits before you receive the medical care. You will be notified of a decision on your Pre-Service Claim (whether approved or denied) within 15 days of the receipt of a properly completed claim form, unless additional time is needed. The time for response may be extended for up to an additional 15 days if necessary, due to matters beyond the control of the appropriate claims-processing entity. You will receive written notification of such extension before the end of the initial 15-day period. The notice of an extension will set forth the

circumstances requiring an extension of time and the date by which a decision is expected to be made.

If you improperly file a Pre-Service Claim, you will be notified within 5 days after receipt of the claim of the proper procedures to re-file the claim. If the claim is not properly re-filed, it will not constitute a claim. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended from the date of the extension notice for either 45 days or until the date on which your response is received, whichever is earlier. The appropriate claims-processing entity will then have 15 days to make a decision on your Pre-Service Claim and notify you of its determination.

**Urgent Care Claims**

An Urgent Care Claim is a Pre-Service Claim that requires shortened time periods for making a determination because the longer time periods for making non-Urgent Care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a Doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim.

If your Urgent Care Claim is filed improperly, you will be notified of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. You will be notified of the decision on your Urgent Care Claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the Plan.

If more information is needed to decide your Urgent Care Claim, you will be notified of the specific information necessary to complete the claim within 24 hours after receipt of the claim by the appropriate claims-processing entity. You will then have up to 48 hours to provide the requested information. You will be notified of the decision within 48 hours after the earlier of:

- The Fund's receipt of the specified information, or if earlier,
- The end of the period you were given to provide the specified information.

**Concurrent Care Claims**

A Concurrent Care Claim is a claim that is reconsidered after an initial approval was made and

results in a reduction, termination or extension of a benefit. An example of a Concurrent Care Claim is an inpatient Hospital stay that was initially certified for five days and is reviewed at three day intervals to determine if additional days are appropriate. In this case, the decision to reduce, end or extend treatment is being made while treatment is taking place.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care Claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care Claims (see above), except that you will be notified of the decision (whether approved or denied) within 24 hours after receipt of the claim, provided that the claim is properly filed at least twenty-four 24 hours before the end of the previously approved period of time or number of treatments.

**Post-Service Claims**

A Post-Service Claim is any claim submitted for payment after health services and treatment have already been obtained. If your Post-Service Claim is denied, in whole or in part, you will be notified of the claim denial within 30 days after the claim is received. The period for a decision may be extended for up to 15 additional days due to matters beyond the control of the appropriate claims-processing entity, provided that you receive advance written notice of such extension before the end of the initial 30-day period expires. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which a decision is expected to be made.

If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given 45 days from receipt of the notice to provide the requested information. If you do not provide the information requested, your claim will be decided based on the information available. During this 45-day period, the deadline for making a decision on your claim will be suspended for either 45 days or until the date on which your response is received, whichever is earlier.

**Disability Income Claims**

If you improperly file a claim for Disability Income, the Fund Office will notify you as soon as possible and give you the opportunity to properly re-file the claim. Keep in mind that if a claim form has to be returned to you for more information, delays in payment may result. The Fund reserves the right to have a doctor examine you (at the Fund's expense) as often as is reasonable, determined within the discretion of the Board of Trustees.

If your claim is denied, you will receive notification within 45 days of the date your claim is filed. If the Fund requires additional time due to matters beyond the control of the Fund, you will be notified of the reason for the delay and when the decision is expected to be made before the expiration of the initial 45-day period. The Fund will make its decision within 30 days of notifying you of the delay.

If an extension is needed because additional information is required 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, your claim will be decided based on the information provided.

**Supplemental Health Reimbursement Account Claims**

If you wish to receive a reimbursement from your Supplemental Health Reimbursement Account, you must provide the Fund Office with a claim form. For reimbursements from the Supplemental Health Reimbursement Account, you must also include appropriate supporting documentation as described in Appendix A. You will receive a decision within 30 days of the date your claim is received by the Fund. This period may be extended by an additional 15 days if an extension is necessary. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a determination is expected to be made.

If an extension is needed because additional information is required 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, your claim will be decided based on the information provided.

**Claims Denial Notification**

You will be provided with a written notice of any denial of a claim (whether denied in whole or in part), which will include the following information:

- The claim involved (including the date of service, the provider involved, if applicable, and the claim amount);
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- if the denial of your claim was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- a description of any additional material or information necessary to support the claim, and an explanation of why the material or information is necessary;
- a description of the appeal procedures (including voluntary appeals, if any) and external review process and applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- for Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims (keep in mind that for Urgent Care Claims, you may

first be notified over the phone or in person, with written notification to follow).

As part of the Fund's internal claims and appeals review process, you have the right to review your claim file and to present evidence and testimony in support of your claim and appeal. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the Fund, the Board of Trustees, or the Fund's other applicable claims-processing entities.

**Appealing a Denied Claim**

For life insurance, which is an insured benefit, refer to your insurance booklet for information as to how to file a claim or appeal.

For Uninsured Claims other than Prescription Drug Claims:

If your uninsured claim is denied in whole or in part, or if you disagree with the decision made on a claim, you can file an appeal with the Fund's Board of Trustees. Your request for review must be made in writing to the Fund Office within 180 days after you receive notice of denial. Appeals involving Urgent Care Claims may be made orally by calling the Fund Office.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation, and application of the Plan. The decision of the Board of Trustees is final and binding. Please remember that you are not required to appeal a decision regarding your claim. However, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to seek external review or file suit in state or federal court. You have a right to file suit in federal or state court under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") on your claim for benefits. Failure to exhaust these administrative remedies will result in the loss of your right to file suit.

In support of your appeal, you have the right to:

- Present evidence and written testimony relating to your claim, including written comments, documents, records, and other information relating to your claim for benefits;

- Upon request, obtain reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits; and

- Review your claim file.

In making a decision on review, the Board of Trustees or an authorized committee of the Board of Trustees will review and consider all comments, documents, records, and other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered during the initial claim determination. In reviewing your claim, the Board of Trustees will not automatically presume that the Fund's initial decision was correct, but will independently review your appeal. If any new or additional evidence is

considered in connection with your appeal, that evidence will be provided to you, free of charge, as soon as possible, and the Fund will give you an opportunity to respond. Further, if the decision is based on a new or additional rationale, you will receive an explanation of the rationale, and the Fund will give you an opportunity to respond before a final determination is made on your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate), the Board of Trustees will consult with a health care professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Fund on the initial claim.

In the case of an appeal of an Urgent Care Claim, the Board of Trustees or an authorized committee of the Board of Trustees will notify you of the decision on your appeal within 72 hours after the Fund's receipt of your appeal. In the case of an appeal of a Pre-Service Claim or a Concurrent Care Claim, the Board of Trustees or an authorized committee of the Board of Trustees will notify you of the decision regarding your appeal within 30 days after the Fund's receipt of your appeal. The Fund may also request that you voluntarily extend the period of time for the Board of Trustees to make a decision on your appeal.

For Post-service Claims, the Board of Trustees or will hear your appeal at its next regularly scheduled meeting that is at least 30 days after your appeal is received. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing of the circumstances requiring the extension and the date on which a decision is expected. In no event will a decision be made later than the third meeting after receipt of your appeal. The Trustees will send you a written notice of their decision (whether approved or denied) within 5 days of the date on which the decision is made.

For Prescription Drug Claims:

If your appeal for prescription drug benefits is denied in whole or in part, you have 180 days to appeal that denial to Express Scripts. If your appeal is denied by Express Scripts, you may file a second appeal with Express Scripts within 60 days after the date on which your first appeal is denied. You are not required to file a second appeal, however, you must do so in order to be eligible to file a lawsuit under ERISA or to seek external review by an Independent Review Organization, as described below.

With respect to prescription drug claims decided by Express Scripts, a decision will be made regarding your appeal within 30 days of the date on which Express Scripts receives your first level appeal and within 30 days of the date on which Express Scripts receives your second level appeal.

Notification of Appeal Denial

If your appeal is denied, you will be notified of the following:

- The claim involved (including the date of service, the provider, if applicable, and the claim amount);

- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered a request for external review);
- The specific reason or reasons for denial, including the standards used and a discussion of the decision;
- Reference to specific Plan provisions on which the denial is based;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- If the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement of your right to seek external review and to bring a civil action under Section 502(a) of ERISA following a denial of your appeal.

**External Review of Denied Claims**

If your claim for uninsured benefits has been denied and if you have exhausted the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an external independent review organization (IRO). External review is limited to claims involving medical judgment (e.g., lack of Medical Necessity, or a determination that a claim is Experimental or cosmetic) or a rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal). Requests for external review are generally filed with the Fund office except that requests involving prescription drug claims must be filed directly with Express Scripts.

*Preliminary Review*. Within five business days of receiving your request for an external review, the Fund, or Express Scripts, as applicable, will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the Fund's claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review, except to the extent required by law, that the preliminary review may be referred to an IRO to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

*Referral to Independent Review Organization* ("IRO"). If your external review request is complete and your claim is eligible for external review, your claim will be forwarded to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within ten business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the Fund, or Express Scripts as applicable. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund, or Express Scripts, as applicable, decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives, and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- A general description of the claim and the reason for the external review request;
- The date the IRO received the external review assignment and the date of its decision;
- Reference to the evidence considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to you; and
- Contact information for any applicable consumer assistance office.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

*Reversal of the Fund's decision*. If the IRO issues a final decision that reverses the Fund's decision, the Fund will pay the claim.

**Expedited External Review of Denied Claims**

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant

has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted to the Fund's Board of Trustees.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The Fund will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision on as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

# Lawsuits

If you wish to file suit for a denial of a claim of benefits, you must do so within two years of the later of the date on which (i) the Trustees denied your appeal or (ii) the IRO rendered a decision against you on external review. For all other actions, you must file suit within two years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the Trustees, you must file suit in one of the United States District Courts in the State of New York. These rules apply to you and your spouse or other dependents. This Section applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

# Privacy of Protected Health Information

**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.**

These provisions will remain in effect unless and until the Fund provides you with a revised Notice of Privacy Practices.

The Fund is committed to protecting the privacy of your protected health information Health information is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. This Section constitutes the Fund's Notice of Privacy Practices. In accordance with applicable law, you have certain rights under the privacy rules of Health Insurance Portability and Accountability Act of 1996 ("HIPAA") the related regulations ("federal health privacy law"), as described in this Section, related to your health information. Specifically, you have the right to:

- maintain the privacy of your health information;
- receive this notice describing the Fund's legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this provision.

## INFORMATION SUBJECT TO THIS SECTION

The Fund collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Fund obtains this health information from forms that you complete, through conversations you may have with the Fund's administrative staff and health care professionals, and from reports and data provided to the Fund by health care service providers or other employee benefit plans. This is the information that is subject to the privacy practices described in this Section. The health information the Fund has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information.

## SUMMARY OF THE FUND'S PRIVACY PRACTICES

**The Fund's Uses and Disclosures of Your Health Information.** The Fund uses your health information to determine your eligibility for benefits, to process and pay your insured health benefits claims, including HRA reimbursements, and to administer its operations. The Fund discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Fund may also disclose your health information to third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Fund's uses and disclosures of your health information are described below.

**Your Rights Related to Your Health Information.** The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- Request access to your health information in an electronic format;
- File a complaint with the Fund office or the Secretary of the U.S. Department of Health and Human Services if you believe that your that privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below. The Fund reserves its right to change its privacy practices as described below.

**Contact Information.** If you have any questions or concerns about the Fund's privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund's privacy practices, please contact:

HIPAA Privacy Officer
Northeast Carpenters Health Fund
91 Fieldcrest Avenue
Edison, New Jersey 08818
(732) 417-3900

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Fund uses and discloses your health information only for the administration of the Fund and the processing of your health claims.

## DETAILED NOTICE OF THE FUND'S PRIVACY POLICIES

**Uses and Disclosures for Treatment, Payment, and Health Care Operations.**

- **For Treatment.** Although the Fund does not anticipate making disclosures "for treatment," if necessary, the Fund may make such disclosures without your authorization. For example, the Fund may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.

- **For Payment.** The Fund may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Fund's program of benefits. For example, the Fund may share your enrollment, eligibility, and claims information with the Fund's claim processors, so that they may process your claims. The Fund may use or disclose your health information to health care providers to notify them as to whether certain medical treatment or other health benefits are covered. The Fund also may disclose your health information to insurers or other benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs. In addition, the Fund may disclose your health information to claims auditors to review billing practices of health care providers and to verify the appropriateness of claims payment.

- **For Health Care Operations**. The Fund may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Fund may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Fund.

**Uses and Disclosures to Business Associates.** The Fund shares health information about you with its "business associates," which are third parties that assist the Fund in its operations. The Fund discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Fund shares your health information with the Fund's claim processors so that they may process your claims. The Fund may disclose your health information to auditors, actuaries, accountants, and attorneys as described above. In addition, if you are a non-English speaking participant who has questions about a claim, the Fund may disclose your health information to a translator; and the Fund may provide names and address information to mailing services.

The Fund enters into agreements with its business associates to ensure that the privacy of your health information is protected.

**Uses and Disclosures to the Plan Sponsor.** The Fund may disclose your health information to the Fund's Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Fund, without your authorization. The Fund also may disclose your health information to the Trustees for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Trustees, the Trustees will certify to the Fund that it will protect your health information and that included language in this document to reflect its obligation to protect the privacy of your health information.

**Other Uses and Disclosures That May Be Made Without Your Authorization.** As described below, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization.

- **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
    - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
    - To report information related to victims of abuse, neglect, or domestic violence.
    - To assist law enforcement officials in their law enforcement duties.
- **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
- **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.
- **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
- **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

- **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

- **Others Involved In Your Care**. Under limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Fund has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Fund). Also, upon request, the Fund may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as below.

- **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

- **Treatment and Health-Related Benefits Information**. The Fund and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.

- **Research**. Under certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

- **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

- **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

**Uses and Disclosures for Fundraising and Marketing Purposes**. The Fund and its business associates do not use your health information for fundraising or marketing purposes.

**Any Other Uses and Disclosures Require Your Express Authorization.** Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Fund will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Fund already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health

information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

## YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Fund creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Northeast Carpenters Health Fund
91 Fieldcrest Avenue
Edison, New Jersey 08818
(732) 417-3900

**Right to Inspect and Copy Health Information.** You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your Fund eligibility, plan coverage, claim records, and billing records. For health records that the Fund keeps in electronic form, you may request to receive the records in an electronic format. To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. Upon receipt of your request, the Fund will send you a claims report that is a summary of your claims history that covers the previous six years. If you have been eligible for benefits for less than six years, then the report will cover the entire period of your coverage.

If you do not agree to receive a claims history report, and instead want to inspect and/or obtain a copy of some or all of your underlying claims record, which includes information such as your actual claims and your eligibility/enrollment card and is not limited to a six-year period, state that in your written request, and that request will be accommodated. If you request a paper copy of your underlying health record or a portion of your health record, the Fund will charge you a fee of $.25 per page for the cost of copying and mailing the response to your request. Records provided in electronic format may also be subject to a small charge to reflect the Fund's labor costs in providing you the records.

In certain limited circumstances, the Fund may deny your request to inspect and copy your health record. If the Fund does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

**Right to Request That Your Health Information Be Amended.** You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Fund may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for the Fund, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Fund;
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Fund will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Fund denies your request, it will explain how you can continue to pursue the denied amendment.

**Right to an Accounting of Disclosures.** You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Fund to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. In response to your request for an accounting of disclosures, the Fund may provide you with a list of business associates who make such disclosures on behalf of the Fund, along with contact information so that you may request the accounting directly from each business associate. The first accounting that you request within a twelve-month period will be free. For additional accountings in a twelve-month period, you will be charged for the cost of providing the accounting, but the Fund will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

**Right to Request Restrictions.** You have the right to request restrictions on your health care information that the Fund uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that the Fund discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. Except in the case of disclosures for payment purposes where you have paid the health care provider in full out of pocket, the Fund is <u>not</u> required to agree to your request for such restrictions, and the Fund may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

**Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location.** You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For

example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

**Right to Complain.** You have the right to complain to the Fund and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Fund, submit a written complaint to the HIPAA Privacy Officer listed above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Fund or with the Department of Health and Human Services.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. To make such a request, submit a written request to the HIPAA Privacy Officer listed above.

**Right to Receive Notice of a Breach of Your Protected Health Information**. We are required to notify you if your unsecured protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of unsecured protected health information. The notification requirements under this section apply only if the breach poses a significant risk for financial, reputational, or other harm to you. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every disclosure of health information is a breach that requires notification: you may not be notified if the health information that was disclosed was adequately secured—for example, computer data that is encrypted and inaccessible without a password—or if the Fund determines that the disclosure does not pose a significant risk of harm to you.

## CHANGES IN THE FUND'S PRIVACY POLICIES

The Fund reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Fund materially changes any of its privacy practices, it will revise its Notice and provide you with the revised Notice, either by U.S. Mail or e-mail, within sixty days of the revision.

## BOARD OF TRUSTEES OBLIGATIONS WITH RESPECT TO PROTECTED HEALTH INFORMATION

In order to permit the Fund's Board of Trustees to carry out its administrative duties with respect to the Fund, the Board of Trustees may, consistent with the federal privacy rules, receive protected health information ("PHI") from the Fund or the Fund's health insurer and other providers, subject to the following restrictions:

- The Board of Trustees may use and disclose PHI as necessary to administer the benefits described in this booklet, to the extent consistent with law and the Fund's governing documents. Except as permitted by Business Associate Agreements (as described above), no individuals will be given access to PHI intended to be disclosed to the Trustees.

- The Board of Trustees may only receive PHI from the Fund or the Fund's health insurer after the Trustees have advised, in writing, of their adoption of these rules governing the use and disclosure of PHI as required by applicable law. In addition, the Board of Trustees will:

    - not use or further disclose PHI other than as permitted or required by the Fund's governing documents or as required by law;

    - ensure that any agents, including subcontractors, to whom the Trustees provide PHI that is received from the Fund or health insurer, agree to the same restrictions and conditions that apply to the Trustees with respect to such information;

    - not use or disclose the information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees;

    - report to the Fund or, if applicable, the Fund's health insurer, any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures of which the Board of Trustees becomes aware;

    - make PHI available to Participants in accordance with applicable law;

    - make PHI available to Participants for amendment, and incorporate any amendments to PHI, in accordance with applicable law;

    - make available to Participants the information required to provide an accounting of disclosures in accordance with applicable law;

    - make the Board of Trustees' internal practices, books, and records relating to the use and disclosure of PHI received from the Fund or, if applicable, from the Fund's health insurer, available to the Secretary of Health & Human Services upon request for purposes of determining compliance by the Fund;

- to the extent possible, return or destroy all PHI received from the Fund or health insurer, that the Board of Trustees maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that adequate separation between the Fund and the Board of Trustees exists to assure the confidentiality of the PHI, as required by applicable law.

- In addition, the Board of Trustees will:

  - implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;

  - ensure that the adequate separation between the Board of Trustees and the Fund is supported by reasonable and appropriate security measures

  - ensure that its agents and Business Associates to whom it provides electronic PHI agree to implement reasonable and appropriate security measures; and

  - report to the Fund any security incident of which the Board of Trustees becomes aware.

# Other Information You Should Know

**Financing the Plan**

Contributions to the Fund are made by Employers that have entered into a collective bargaining agreement with the Union or other written agreement with the Trustees requiring that contributions be made to the Fund. However, in some instances, you may be entitled to benefits from the Fund if you work under the jurisdiction of another welfare fund that is party to a reciprocity agreement with the Fund. In these instances, your employer's contributions to the other fund will be transferred to this Fund provided you properly complete the required forms.

**How Benefits May Be Forfeited or Delayed**

There are certain situations under which benefits may be forfeited or delayed. Most of these circumstances are spelled out in the previous Sections, but benefit payments also may be forfeited or delayed if you:

- do not timely submit a claim for benefits;
- do not provide the information required to complete or verify a claim; or
- do not have a current address on file with the Fund Office.

Plan benefits are not payable for any enrolled Dependents who are ineligible due to age, divorce or legal separation unless such Dependent timely elects to continue coverage under COBRA, as described in pages 21-22.

If the Fund mistakenly pays more than you are eligible to receive or pays benefits that are not authorized by the Plan, the Fund may seek any permissible remedy allowed by law to recover these benefits. (Please refer to the section on Overpayments on page 61 and Subrogation on pages 58).

**No Liability for the Practice of Medicine**

Neither the Fund, nor the Board of Trustees or any of its designees:

- are 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; and
- will have any liability whatsoever for any loss or injury caused by any health care provider by reason of negligence failure to provider care or treatment, or otherwise.

**Compliance with Law**

The Fund is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor and current tax and ERISA laws. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law takes precedence over state laws.

**Plan Amendment or Termination**

The Board of Trustees intends to continue the Plan indefinitely, but reserves the right to amend or terminate it in its sole discretion. Please remember that benefits provided under this Plan are not vested. Therefore, at any time, the Board can end or amend benefits, in its sole and absolute discretion.

# Coordination of Benefits

You and/or your Dependents may have health care coverage under another plan. For example, your spouse may have employer-provided health insurance or be enrolled in Medicare. When this occurs, the two plans will coordinate benefit payments so that the combined payments do not exceed the maximum covered charges (or the actual cost, if less). This process, which is referred to as Coordination of Benefits, determines which plan pays first for your health care and which plan pays second. The plan that pays first is referred to as your primary plan and the plan that pays second is the secondary plan. The primary plan will reimburse you first and the secondary plan will reimburse you for the remaining expenses up to the maximum covered amount. Except for coordination with Medicare or TRI-CARE, the following rules are used to determine which plan is your primary plan:

- If the other plan does not have a coordination of benefits provision, that plan is always primary.
- The plan that covers the patient as an active employee is primary and the plan that covers the patient as a dependent is secondary.
- If the patient is covered both as an active employee (or dependent of an active employee) and as either a laid-off employee or a retired employee, then the active employee's plan will be primary. However, if the other plan does not have this rule and the two plans do not agree as to which plan is primary, than this rule will not apply.
- If the patient is a Dependent child of parents not separated or divorced, then the plan covering the parent whose birthday falls earlier in the calendar year pays first. If the other plan does not use the "birthday rule," then that plan is primary unless the primary plan is already determined under the above rules.
- If the patient is a Dependent child of parents who are legally separated or divorced, the plan of the parent with whom the child lives for a majority of the year will be primary; the other parent's plan will be secondary. In the event the parent with whom the child lives has remarried, the plan of that parent (or stepparent) will be primary and the plan of the other parent will be secondary. If there is a court decree giving one parent financial responsibility for the medical expenses, then that parent's plan becomes primary without regard to any other rules in this paragraph.
- If none of the above rules establish which plan is the primary plan, the plan that has covered the patient the longest, continuously, during the period in which the expense is incurred, is the primary plan.

If both you and your spouse are Participants under this Plan, your benefits are coordinated in the same manner as everyone else. You will not be reimbursed more than the maximum allowed amount for the covered services and you will not be reimbursed for any Co-payments.

Please note that if optional employer-sponsored health coverage is available to a covered spouse and the spouse elects to not be covered under such plan, this Plan will apply the Coordination of Benefits provisions as though the optional coverage were in effect. Therefore, your Dependents are encouraged to enroll any other coverage available to them. Failure to do so may result in less coverage under this Plan.

**Medicare.** Generally, the Fund will be the primary payer for participants over the age of 65 working in Covered Employment and their spouse. However, if you are receiving coverage from the Fund under COBRA, Medicare, and not the Fund, will be primary, to the extent permitted by applicable law. Also, an active employee or spouse may decline coverage under the Plan and elect Medicare as primary. In that instance, the Fund will not pay benefits secondary to Medicare for Medicare covered services.

If you or your Dependents become eligible for Medicare due to disability while you are actively working in Covered Employment, this Plan will provide your primary coverage and Medicare will be secondary for as long as you continue to work in Covered Employment. If you are not working in Covered Employment, and you or your Dependents become eligible for Medicare due to disability, Medicare is primary and this Plan is secondary for each covered family member

eligible for Medicare. Any covered family members not eligible for Medicare will receive primary coverage under this Plan.

For covered patients with *end-stage renal disease*, Medicare is the secondary payer during the first 30 months of treatment. After this 30-month period is over, Medicare permanently becomes the primary payer. This is true even if Medicare would be secondary for some other reason. This Plan will pay secondary after the first 30-month period even if you fail to enroll in Medicare coverage.

Please note that if you or your Dependents are eligible for Medicare but choose not to enroll in Medicare coverage, this Plan will apply the Coordination of Benefits rules as though you and/or your Dependents are enrolled in Medicare. Therefore, you are encouraged to enroll in Medicare when you become eligible.

**TRI-CARE**. If you or your Dependents are covered under TRI-CARE, this Plan pays primary and TRI-CARE pays secondary.

**No-fault benefits.** If a person covered by this Plan has a claim which involves a motor vehicle accident covered by the "No-Fault" insurance law of any state, health care expenses must be reimbursed first by the "No-Fault" insurance carrier. Only when the claimant has exhausted his health care benefits under the "No-Fault" coverage may such individual be entitled to receive health care coverage under this Plan. You must submit proof from No-Fault carrier that your insurance is exhausted. If there are expenses for services which are covered under this Plan and which are not completely reimbursed by the "No-Fault" carrier, this Plan will consider for reimbursement claims for the difference, subject to the Plan's applicable maximums and other provisions.

**Workers Compensation**. This Plan does not cover benefits for expenses covered by Workers Compensation or occupational disease laws. If an employer disputes the application of Workers Compensation laws for an illness or injury, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under Workers Compensation or occupational disease law.

| PLAN FACTS | |
|---|---|
| **Plan Name** | Northeast Carpenters Health Fund |
| **Edition Date** | This Summary Plan Description includes the rules of the Plan as of July 1, 2017. |
| **Plan Sponsor and Plan Administrator** | Board of Trustees<br>Northeast Carpenters Health Fund<br>91 Fieldcrest Avenue<br>Edison, New Jersey 08818<br>(732) 417-3900 |
| **Employer Identification Number** | 22-6032181 |
| **Plan Number** | 501 |
| **Type of Administration and Funding of Benefits** | The Fund is a self-insured multiemployer welfare plan. The only insured benefits offered under the Plan are life insurance and dental |
| **Plan Year End** | December 31st |
| **Agent for Service of Legal Process** | Peter Tonia, Fund Director<br>Northeast Carpenters Health Fund<br>91 Fieldcrest Avenue<br>Edison, New Jersey 08818<br>(732) 417-3900<br>In addition, service of legal process may also be made upon any Fund Trustee.<br>The names of the Funds Trustees are listed on page 2. Service of process on a Trustee must be made to the Fund's New Jersey Office. |
| **Sources of Plan Contributions** | Contributions are generally made by Employers pursuant to the terms of a collective bargaining agreement with the Union or participation agreement with the Trustees. In addition, some individuals may be eligible to participate in the Plan pursuant to the terms of a reciprocity agreement with this Fund and another welfare plan. |
| **Collective Bargaining Agreements** | The Fund is maintained in accordance with collective bargaining agreements. You may examine any collective bargaining agreement maintaining the Plan at the Fund office during normal business hours. In addition, you may request a copy of a collective bargaining agreement to be sent you by sending a written request to the Fund Office. |
| **Participating Employers** | Upon receipt of a written request, the Fund Office will provide you with information as to whether a particular employer contributes to the Plan. Additionally, a complete list of all Contributing Employers and Unions sponsoring the Plan can be obtained upon written request to the Fund office. |
| ADMINISTRATIVE CONTACTS | |
| **Medical/Hospital** | In-Network:<br>Empire Blue Cross and Blue Shield<br>P.O. Box 1407<br>Church Street Station<br>New York, NY 10008<br>(212) 476-1000<br><br>Out-of-Network:<br>Lifetime Benefit Solutions<br>P.O. Box 780<br>Liverpool, NY 13088-0780 |

| | |
|---|---|
| **Prescription Drug** | Express Scripts<br>P.O. Box 14711<br>Lexington, KY 40512 |
| **Employee Assistance Program** | Lower Hudson Valley EAP<br>3505 Hill Blvd,. Suite A<br>Yorktown Heights, NY 10598 |
| **Life Insurance** | Dearborn National NY<br>1020 31st Street<br>Downers Grove, IL 60515-5591 |
| **Disability, Supplemental HRA** | Northeast Carpenters Health Fund<br>270 Motorway Parkway<br>Hauppauge, New York 11788<br>(631) 952-9700 |
| **Dental** | Cigna<br>P.O Box 188037<br>Chattanooga, TN 37422-8037 |
| **Vision** | Davis Vision<br>Vision Care Processing Unit<br>P.O. Box 1525<br>Latham, NY 12110 |

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions, financial or otherwise, so warrant.

# Your Rights Under ERISA

As a participant in the Empire State Carpenters Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse or your Dependents 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. You should review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Fiduciaries**

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

**Enforce your Rights**

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

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

**Assistance With Your Questions**

If you have any questions about the Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension Employee Benefits Security Administration.

## Appendix A

### Eligible Medical Expenses

**Please remember that just because an expense is included on this list, does not mean that it is automatically reimbursable from the Health Reimbursement Account. All the applicable requirements described in the SPD must be met in order for your claim to be eligible for reimbursement. In addition, the Fund reserves the right to request additional information that is not included in this Appendix to determine whether a particular expense is reimbursable.**

| Healthcare Expense Type | Substantiation Requirements |
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| Co-Payments, Co-insurance, Deductibles and expenses that exceed the Usual or Customary Charges paid to out-of-network providers for expenses. This includes, but is not limited to, doctors, hospitals, urgent care facilities, laboratory services, radiology services, ambulance transport, mental health services, substance abuse treatment, orthotics and prosthetics. | • Explanation of Benefits (EOB) or Health Statement<br>• If payment is being made to the covered person, proof of payment (original receipts or a clearly legible photocopy).<br>• If payment is being made directly to the provider, you must provide an assignment claim form and a W-9 Form completed by the provider<br>• If an EOB or Health Statement is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include:<br>1. Date of service<br>2. Patient name<br>3. Description of services rendered (procedure code and diagnosis code if available)<br>4. Cost of services rendered<br>5. Name and address of provider. |
| **Medical Premiums**<br>• Post-tax medical, dental or vision premiums that are paid to a qualified individual or group health plan.<br>• Medicare<br>• COBRA premiums that are paid to a qualified individual or group health plan<br>• Premiums that are self-paid to the Fund with after-tax dollars during a period in which your Employer is delinquent<br>• Does **not** include the cost of purchasing insurance through a State Health Plan marketplace | • For premiums for the Fund's medical plan, you do not need to present any additional documentation. If you elect this coverage, the Fund will automatically deduct the monthly premiums from your HRA.<br>• Acceptable Proof:<br>1. Proof that premiums are paid with "after tax dollars," such as a letter from Human Resources or Payroll department.<br>2. Paycheck stub showing the amount of premiums paid. Pay stub must also include; date the check was issued, name of person the check is issued to and the amount of premium deducted.<br>3. Proof that the plan is a qualified individual or group health plan.<br>4. Copies of Medicare statements or invoices are acceptable.<br>5. For COBRA premiums, proof must include a letter from the Plan Administrator certifying the COBRA rate and proof that you have paid the full premium. |
| **Dental and Orthodontic Services**<br>• Premiums for Fund's dental plan<br>• Premiums you pay to purchase your own dental coverage with after tax-dollars<br>• Dental services for the prevention and alleviation of dental disease, including preventive services such as teeth cleaning, sealants, and fluoride treatments, and | • For premiums for the Fund's dental plan, you do not need to present any additional documentation. If you elect this coverage, the Fund will automatically deduct the monthly premiums from your HRA.<br>• For premiums for insurance you purchase on your own, you must provide an invoice from the insurance; proof of payment and proof that payment was made with after-tax dollars. |

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| services such as X-rays, braces (adult or child), extractions or dentures.<br>• Cosmetic dental services and teeth whitening are not reimbursable. | • For dental or orthodontic Services<br>- Explanation of Benefits (EOB) if you have dental coverage or a bill from your provider if you do not have dental coverage;<br>- If reimbursement is being made directly to you, proof of payment is required;<br>- If payment is being made directly to the provider, you must submit an assignment claim form and a W-9 form completed by the provider;<br>- Orthodontics also require a signed and dated Orthodontic contract with provider information, patient name, payment plan selected and the amount, of any an insurance company is estimated to pay. |
| **Drugs/Medicines – Prescriptions**<br><br>Expenses for fertility drugs and over-the-counter-drugs, including vitamins and supplements , are reimbursable only if the Participant or Dependent, as applicable, has a prescription from a doctor or other authorized medical professional. Marijuana is not reimbursable.<br><br>In order for vitamins and nutritional supplements to be reimbursed, they must be recommended by a licensed medical practitioner as treatment for a specific medical condition that was diagnosed by a physician. | • Documentation from the Pharmacy that must include all of the following:<br>1. Name and Address of Pharmacy<br>2. Name of patient<br>3. Name of Drug<br>4. Cost of Drug and any amounts covered by insurance<br>5. Prescribing doctor<br>• If payment is being made directly to the covered person, proof of payment (original receipts or a clearly legible photocopy).<br>• If payment is made directly to the provider, you must provide an assignment form and a W-9 Form completed by the provider.<br>• For vitamins and nutritional supplements, you must also provide a letter from a licensed medical provider explaining the medical condition and how the vitamin/supplement is expected to treat that condition.* |
| **Vision Care**<br>• Prescription eyewear includes Frames/Lenses or Contact lenses<br>• Eye examinations by a licensed ophthalmologist, optometrist or optician<br>• Laser surgery | • Explanation of Benefits (EOB) or Health Statement is preferable<br>• If payment is being made to the covered person, proof of payment (original receipts required or a clearly legible photocopy).<br>• If payment is being made directly to the provider, you must provide an assignment form and a W-9 Form completed by the provider<br>• If an EOB or Health Statement is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include:<br>1. Date of service<br>2. Patient name and date of birth<br>3. Description of services rendered (procedure code and diagnosis code if available).<br>4. Cost of services rendered<br>5. Name and address of provider. |
| **Hearing**<br>• Purchase price and maintenance cost for hearing aids | • Explanation of Benefits (EOB) or Health Statement<br>• If payment is being made to the covered person, proof of payment (original receipts or clearly |

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| • Batteries needed to operate the hearing aid<br>• Hearing exams<br><br>**If you are not eligible for hearing aid coverage because of age, you can still seek reimbursement from the HRA for hearing services, provided all the other requirements of this SPD are satisfied and you submit a copy of your prescription and a letter of medical necessary.** | legible photocopy).<br>• If payment is being made directly to the provider, you must provide an assignment form and a W-9 Form completed by the provider<br>• If an EOB is not available or if payment is being made directly to the provider, you must submit an itemized bill which must include:<br>1. Date of service<br>2. Patient name<br>3. Description of services rendered (procedure code) and diagnosis code if available<br>4. Cost of services rendered<br>**5.** Name and address of provider. |
| **Durable Medical Equipment**<br>• Must have a prescription for the equipment | • Copy of the prescription or proof that the equipment was prescribed<br>• Letter of Medical Necessity<br>• Proof of payment, if not being paid directly to provider<br>• If payment is being made directly to the provider, submit an assignment claim form and a completed W-9 Form<br>• Documentation that includes the following:<br>1. Name and Address of Company proving the equipment<br>2. Name of patient<br>3. Type of Equipment<br>4. Cost of Equipment and any amounts covered by insurance<br>5. Prescribing doctor |
| **Lodging and Transportation Expenses** – Lodging expenses for a Participant or Dependent are reimbursable if (1) the lodging is primarily for, and essential to, medical care; (2) the medical care is provided by a physician at a licensed hospital or a medical care facility that is related to, or the equivalent of, a licensed hospital; and (3) there is no significant element of personal pleasure, recreation or vacation in the travel away from home. Lodging expenses are also reimbursable for one companion of the patient if the presence of the companion is necessary for the patient to receive medical care. In no event will any reimbursement for lodging exceed $50 per night per person.<br>Transportation costs, including parking fees, are also reimbursable if: 1) they are incurred primarily for, and essential to, the receipt of medical care by the Participant or Dependent; and 2) are incurred in connection with lodging expenses reimbursed from the HRA. Transportation costs of a family member traveling with the Participant or Dependent are also reimbursable if the family member's presence is necessary for the patient to receive medical care. In no event will transportation costs be reimbursed unless they are incurred in connection with reimbursable lodging expenses. | • Records from the hospital or equivalent facility showing the dates of treatment, diagnosis, and services rendered.<br><br>• A statement from a licensed physician explaining why treatment was required at the particular hospital or facility.<br><br>• Receipts for the lodging expenses.<br><br>• For transportation costs, receipts for the transportation expenses and statement as to why the transportation costs were necessary to receive medical treatment. |

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| **Massage Therapy**<br><br>To be eligible for reimbursement, you must demonstrate to the satisfaction of the Fund, a clear and direct connection between the massage therapy and the treatment, cure, or mitigation of a specific medical condition. | Proof of payment<br><br>Invoice from the provider explaining the services rendered; and<br><br>A letter from a licensed medical provider explaining your medical condition and how the recommended massage therapy is expected to treat that condition* |
| **Dietary Food and Infant Formulae**<br><br>To be eligible for reimbursement, these items must be: (1) prescribed by a physician; (2) in addition to the individual's normal diet; and (3) not part of the individual's normal nutritional needs.<br><br>Expenses will not be reimbursed for any special food, beverage or formula that is taken as a substitute for that which is normally consumed by a person and satisfies his or her normal nutritional requirements. | A prescription for the specific food/formula<br><br>A letter from a licensed medical provider explaining why this food/formula is necessary and how it is supplemental to, and not a substitute for, the individual's normal nutritional needs*; and<br><br>Proof of payment. |

* The letter required to substantiate a claim for these expenses must specify the period of time for which the course of treatment is required and an explanation as to why this period of time is appropriate for your condition. The Fund will reimburse claims only for the period of time specified in the letter, but in no event more than 12 months. If the particular course of treatment is prescribed for more than a 12-month period, you must submit a new letter at least every 12 months in or for your claim to be eligible for reimbursement, If your treatment is extended beyond the period of time specified in your letter, a new letter must be provided to the Fund,

Remember- just because your medical provider recommends a course of treatment does not mean that it will be eligible for reimbursement from your HRA. It must meet all the requirements described in this document.

The following list provides examples of items that are NOT eligible for reimbursement for your HRA. This list is provided as an example and is not exhaustive.

- Air conditioners and vacuums
- Athletic Club Memberships
- Foods and Beverages, except as otherwise provided above.
- Hot Tubs, Whirlpools, Swimming Pools, Exercise equipment, etc.
- Learning Materials
- Nutrition and Dietary Planning (except Dietary Food as noted above)
- Stop-Smoking Program
- Tanning Bed
- Cancellation Fees, Missed Appointment Fees and Late Payment Fees
- Shipping Fees
- Extended Warranties for Durable Medical Equipment
- New York State medical surcharges
- Marijuana
- Vitamins (except as noted above)