IRON WORKERS LOCALS 40, 361 AND 417

HEALTH AND VACATION FUND

SUMMARY PLAN DESCRIPTION

AND

PLAN DOCUMENT

JANUARY 1, 2022

Iron Workers Locals 40, 361 and 417 Health and Vacation Fund

The Raymond R. Corbett Building

LOCALS 40, 361 & 417
HEALTH FUND
451 PARK AVENUE SOUTH, 9TH FL.
NEW YORK, NY 10016
(212) 684-1586

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January 1, 2022

To All Eligible Participants:

This is your new and updated Health Fund booklet, which sets forth the plan of health and vacation benefits, effective January 1, 2022. This booklet replaces and supersedes any prior booklets summarizing your benefits from the Fund.

Since the Plan was established, the Trustees have adopted changes that have affected almost every aspect of this program. The Trustees adopted these changes to make the benefit program as responsive as possible to your needs, within, of course, the framework of sound financing. These health and vacation benefits are valuable, and should give you a sense of security and peace of mind knowing that you and your family are protected.

We, as Trustees, are naturally pleased to offer this comprehensive benefit program and assure you that we will make improvements whenever possible. As you look through this booklet, you will learn how you become eligible for benefits, what your benefits are, and how you claim them.

As always, the Board of Trustees reserves the right to amend, modify or terminate any benefit provided under the Fund at any time.

Please read this document carefully and keep it where you can refer to it as needed. Be sure to share this information with members of your family since they may also be covered by many of the benefits.

This Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at 212-684-1586. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has information summarizing which protections do and do not apply to grandfathered health plans.

Sincerely,

Board of Trustees

PLEASE REMEMBER YOUR RESPONSIBILITIES

For you and your family to get the most out of Fund benefits, you must remember that it is your responsibility to keep your Fund records up to date. Any information that may affect eligibility for you or your dependents must be furnished to the Fund within 60 days after the event. Therefore, please don't forget to notify the Fund Office immediately when any of the following changes occur:

- you have a change of address (in this case, you should also notify your local union office);
- you have a change in marital status (marriage, divorce, separation, etc.);
- you, your spouse, or dependent(s) have a change in insurance (you enroll or disenroll in another health insurance plan)
- you acquire new dependent children by birth, adoption, marriage (stepchildren), etc.;
- a covered dependent child reaches age 26;
- your employment status changes;
- your spouse or other dependent has, acquires or loses other coverage or health insurance;
- you have not previously completed an enrollment form;
- you want to change your beneficiary designation (you may do this at any time by getting a "Change of Beneficiary" form from the Fund Office and returning the completed form to the Fund Office);
- you or your dependents are involved in an accident or are injured – whether job-related or not;
- you or your spouse becomes eligible for Medicare, or you receive a new or updated Medicare card;
- you retire.

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

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FOR HELP OR REFERENCE

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

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General Plan Information and Eligibility
• Eligibility and Enrollment (Employee, Retiree and Dependent Benefits)
• Information about HIPAA and COBRA (Continuation of Coverage), including premium payments and notices
• Information about USERRA, FMLA, QMCSOs and your Rights under the Plan
• Request documents or other Plan related information
• Replacement ID Cards
• Claim Forms
• General questions about Plan coverage
Medical Benefits
• Medical Claims
• Outpatient Mental Health and Substance Use Disorder Services (Professional/Physician services)
• Medical Plan Information and Out of Network Benefits
Optical Benefits
• Benefit Questions
• Vision Screening, Davis Vision, General Vision Services and Comprehensive Professional Systems, Inc. (CPS) Networks and Provider Directories
Hearing Aid Benefits
• Benefit Questions
• Hear USA, Davis Vision, and General Hearing Services Networks and Provider Directories
Dental Benefits
• SIDS/Metrodent Dental Networks and CPS Dental
• Dental Claims and Appeals
Medicare Part D Prescription Drug Plan
• Eligibility and Enrollment
• Premium and Benefit Questions
Weekly Disability
• Benefit Questions
Vacation Benefits
• Reimbursement Forms
• Benefit Questions
IMPACT Off-the-Job Accident Program
• Benefit Questions
• Claims Forms

</td><td>

Iron Workers Locals 40, 361, and 417
Health Fund
451 Park Avenue South, 9th Fl.
New York, New York 10016
(212) 684-1586
Hours of Operation: 9:00 a.m.- 4:30 p.m.

The Fund Office is the Claims administrator for the Medical, Optical, Hearing Aid, Dental and Vacation Benefits. The Board of Trustees is the claims fiduciary for all appeals, except life and accidental death and dismemberment insurance benefits and hospital benefits.

See Magnacare.com for in-Network Providers or call MagnaCare to request one

</td></tr>
</table>

QUICK REFERENCE CHART

Information Needed	Contact
Hospital Benefits • Hospital Network Provider Directory • Second and Third Opinions • Case Management • Claim Forms • Plan Benefit Information • Inpatient and outpatient facility claims	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Attention: Institutional Claims Department (800) 342-9816 Empire BCBS is the claims administrator and claims fiduciary.
Prescription Drug Benefits • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Specialty Drug Program: Precertification and Ordering	OptumRx PO Box 29044 Hot Springs, AR 71903 (800) 797-9791 www.Optumrx.com OptumRx is the pharmacy benefits manager and claims administrator for prescription drug benefits.
Member's Assistance Program Coordinator • Eligibility • Referral Services to Mental Health and Substance Use Disorder Treatment Facilities and Providers • Drug Testing	Mr. Jim Dufficy Iron Workers Locals 40, 361, and 417 Health Fund 451 Park Avenue South, 9th Fl. New York, New York 10016 (212) 679-1513 (Confidential Telephone Line)
Weekly Disability, Life Insurance and Accidental Death and Dismemberment Benefits • Initiate a Claim • Change and/or update beneficiary information	Questions and completed claims for Disability, Life, and AD&D benefits should be sent to the Fund Administrator at: Iron Workers Locals 40, 361, and 417 Health Fund 451 Park Avenue South, 9th Fl. New York, New York 10016 (212) 684-1586 Hours of Operation: 9:00 a.m.- 4:30 p.m. The Hartford Life Insurance Company insures and administers the Disability, Life, and AD&D benefits.

This Plan contains Coordination of Benefits (COB) provisions to prevent double payment of certain covered expenses. This provision works by coordinating the benefits under this Plan with other plans in which you, or your dependent(s), is a participant so that the total benefits paid for a covered service will not exceed one hundred percent of allowable expenses.

ELIGIBILITY RULES

Initial Eligibility

If you are a new Participant (or if you have been without coverage from the Health Fund for one year or more):

- You become eligible for Medical, Hospital, Prescription Drug, and Life Insurance benefits on the first of the month following the month in which you have worked at least 1,000 hours in covered employment within a 12-month period;
- You become eligible for Dental and Optical benefits after you have maintained medical and hospital coverage for 24 consecutive months; and
- You become eligible for Member's Assistance Program (MAP) coverage when you have met the initial eligibility rule for medical, hospital, prescription drug, and life insurance benefits as noted above.

Coverage begins the first of the month following the month in which you meet any of the above requirements and lasts for two calendar quarters. The term benefits, unless specifically described as "Vacation Benefits," refers to health benefits provided for by the Health Fund. For information about your eligibility for Vacation Benefits, see the "Vacation Benefits" section. You must enroll for benefits; see the Enrollment section for details.

If you are a Residential Iron Worker of the 361 Jurisdiction:

- You become eligible for Medical, Hospital, and Prescription Drug benefits on the first of the month following the month in which you have worked at least 1,000 hours in covered employment in residential work within a 12-month period;
- You will not be eligible for Dental, Optical, Hearing Aid, Life Insurance, Members' Assistance Program or Welfare Fund retiree benefits through your attainment of Health Fund coverage through residential work

Maintaining Eligibility

Once you have achieved initial eligibility, you must work a minimum of 220 hours every other calendar quarter to maintain your eligibility for the next two quarters.

If you are a Residential Iron Worker of the 361 Jurisdiction, you must work a minimum of 375 hours every calendar quarter in order to maintain eligibility for Medical, Hospital, and Prescription Drug coverage for the next quarter.

Termination of Eligibility

Coverage terminates for the participant the earlier of: (1) the last day of the calendar quarter following the quarter after you fail to work 220 hours in covered employment; (2) 31 days following the date you enter military service; (3) the date you die; or (4) the date the plan is discontinued.

However, the first six months during which you are disabled and entitled to benefits under this Health Fund or up to a maximum period of the first five years during which you are entitled to benefits under a Workers' Compensation Law will be disregarded in determining whether you meet the work requirements of these eligibility rules.

If you are a Residential Iron Worker of the 361 Jurisdiction, coverage terminates for the participant the earlier of: (1) the last day of the calendar quarter following the quarter after you fail to work 375 hours in covered employment; (2) 31 days following the date you enter military service; (3) the date you die; or (4) the date the plan is discontinued.

However, the first six months during which you are disabled and entitled to benefits under this Health Fund or up to a maximum period of the first five years during which you are entitled to benefits under a Workers' Compensation Law will be disregarded in determining whether you meet the work requirements of these eligibility rules.

Reinstatement of Eligibility

After you lose eligibility for the Plan, you will be reinstated on the first of the calendar month after which you work at least 220 hours in a calendar quarter in Covered Employment. However, if you have not been eligible for the full schedule of benefits for a period of at least 12 months, you will become eligible again only if you meet the requirements for initial eligibility.

If you are a Residential Iron Worker of the 361 Jurisdiction, after you lose eligibility for the Plan, you will be reinstated on the first of the calendar month after which you work at least 375 hours in a calendar quarter in Covered Employment. However, if you have not been eligible for the full schedule of benefits for a period of at least 12 months, you will become eligible again only if you meet the requirements for initial eligibility.

ELIGIBILITY EXAMPLES

(Applicable to all Participants except to Residential Iron Workers of the 361 Jurisdiction)

Initial Eligibility: John worked 1,000 hours in covered employment during the 12-month period beginning May 1, 2016 through April 30, 2017. His medical, hospital, drug and life insurance coverage will begin on May 1, 2017.

Maintain Eligibility: In order for John to maintain medical, hospital, drug and life insurance coverage, he must work at least 220 hours every other calendar quarter. So still using the example above, let's say that John *does* continue to work after May 1, 2017 and has a total of 220 hours from July 1, 2017 through August 31, 2017. The calendar quarter in which he earned the 220 hours runs from July 1, 2017 through September 30, 2017, so his coverage will continue until March 31, 2018 (that is for six months (or two quarters)) from the end of the calendar quarter in which he worked 220 hours).

Upon maintaining eligibility for a period of 24 months (that period being May 1, 2017 through April 30, 2019) he then becomes eligible for dental and optical benefits as well.

Termination of Eligibility: Following from the previous example, if John does not return to work after August 31, 2017, then his coverage will terminate on April 1, 2018, which is the first day of the calendar quarter following the two consecutive calendar quarters in which he failed to work 220 hours.

Reinstatement of Eligibility: In order for John to have the coverage he lost reinstated, he needs to work 220 hours within a calendar quarter within 12-months from April 1, 2018 through March 30, 2019. So in other words, if John fails to work 220 hours within the following calendar quarters: April 1, 2018 through June 30, 2018; July 1, 2018 through September 30, 2018; October 1, 2018 through December 31, 2018; or January 1, 2019 through March 30, 2019, his coverage will not be reinstated. In order to obtain coverage, he will have to meet the initial eligibility requirements, that is 1,000 hours in covered employment during a 12-month period to obtain medical, hospital, drug and life insurance coverage, and so forth as described in the Maintain Eligibility paragraph above.

However say John *does* work 220 hours within one of the calendar quarters mentioned in the prior paragraph, (say he works 220 hours from April 1, 2018 through May 31, 2018 (calendar quarter ends June 30, 2018), his coverage will be reinstated as of June 1, 2018. The benefits he will receive are the benefits that he had right before his coverage terminated. If he does not work any more hours after May 31, 2018, his coverage will last for at least six months (that is through November 30, 2018) and terminate at the end of the next calendar quarter (December 31, 2018).

Extension of Coverage Due to Work-Related Disability

If you are eligible for Health Fund benefits and your employment is terminated as a result of a work-related disability that occurs while you are performing work for which contributions are required and made to the Plan, and you are receiving benefits under the New York State Worker's Compensation Law, you will be entitled to have all coverage under this Plan extended for up to a period of no more than seven years from the date your coverage would normally have been terminated. If, during this extension period, the Worker's Compensation benefits are terminated and later resumed, your remaining extension period will be seven years, less the number of months for which your Health Fund benefits were extended for that Worker's Compensation award. Any enrolled dependents will also continue to be covered for as long as you are covered. However, the Plan will not reimburse any expenses that are related to an on-the-job accident (see IMPACT Off-the-Job Accident Program section).

Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that the cancellation will be effective back to the time you should not have been covered by the Plan. The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact, failure to timely notify the plan of divorce or due to non-payment of premiums (including COBRA premiums). For rescissions that involve fraud or intentional misrepresentation of material fact, you will be provided with 30 days advance written notice.

Failure to provide complete and accurate information to the Fund Office in a timely manner may constitute intentional misrepresentation of material fact to the Plan.

Pensioner Eligibility

If you retire under the Rules and Regulations of the Iron Workers Locals 40, 361 & 417 Pension Fund on a Regular or Early Retirement with 15 pension credits or more, or an Age 57 Plus 30 Year Service Pensioner, you will be entitled to the benefits under this Plan as outlined in the *Pensioner Benefits* section of this booklet. Your eligible Dependents will also be entitled to the benefits as outlined in that section.

If you retire under the Rules and Regulations of the Iron Workers Locals 40, 361 & 417 Pension Fund as a Disability Pensioner, you will be entitled to the same medical benefits as active participants under this Plan, as outlined in the *Pensioner Benefits* section, for a maximum a period of two years from the effective date of your Social Security Disability award. Active benefits will terminate two years after you become eligible for Social Security disability benefits. At that time, you will be eligible for pensioner benefits which supplement Medicare.

Dependent Eligibility

Eligible Spouse

An employee's/participant's or retiree's Spouse means a person of the opposite gender or same gender who is legally married under State law. The Plan will require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union, a common law marriage, or a spouse of an Eligible Child. If a participant or retiree gets divorced and has not remarried, he can choose to continue coverage for his ex-spouse as an Eligible Spouse. If the Fund receives a notice that the participant or retiree gets divorced, the Fund will terminate the coverage for the ex-spouse and send a COBRA notice. However, the participant or retiree can notify the Fund Office that they wish to maintain coverage for their divorced spouse. If so, that ex-spouse will be considered an "Eligible Spouse" under the plan. If the ex-spouse gets remarried, the ex-spouse will no longer be considered an "Eligible Spouse" and will lose coverage under the plan, unless the ex-spouse elects COBRA continuation coverage. If the participant or retiree remarries, the participant will have the choice of maintaining coverage for the ex-spouse or terminate that coverage and add the new spouse as an Eligible Spouse under the Plan. Please contact the Fund Office for more information.

Eligible Children

For the purposes of this Plan, an Eligible Child is any of the employee's/participant's children listed below who are under the age of 26 (whether married or unmarried):

- Son or daughter (original or certified copy of birth certificate and copy of Social Security card is required)

- Stepson or stepdaughter (original or certified copy of birth certificate, copy of Social Security card, and your marriage certificate to the child's parent are required

- Legally adopted child or child placed for adoption with the participant (proof of adoption or placement for adoption and original or certified copy of birth certificate will be required along with copy of Social Security card)

- A child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) (copy of Social Security card).

- Child for whom the participant or the participant's spouse have been appointed as legal guardian (proof of guardianship, original or certified copy of birth certificate, copy of social security card and marriage certificate, (if applicable) is required) who is fully dependent upon you for support. Such coverage will result in income being imputed to you unless the child is your "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively.

- A Child age 26 or older who is not married, who is permanently and totally disabled and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. The child must be unable to engage in any gainful activity by reason of a medically determinable mental or physical impairment that is expected to result in death or last for a continuous period of 12 months or more, as certified by a doctor, provided:

  - The child is dependent on you for more than one-half of the child's support;
  - The child has a principal place of residence with you for more than one-half of the calendar year (or the entire year in the case of a child for whom you are the legal guardian);

  You provide proof of disability to the Fund Office within the time required by the Trustees.

  Any original documents will be copied and returned to you.

With the exception of a Child who is permanently and totally disabled, coverage for an Eligible Child shall terminate at the end of the month in which the Child attains age 26.

A spouse or child of an Eligible Child is not eligible for coverage under the Plan.

- Proof of other health coverage, if applicable, may be accepted.

Eligible Parents

You may cover your parents under the provisions of the Plan if your parent or parents meet the requirements of IRC Section 152(d) and are considered "qualifying relatives", that is, they are fully dependent upon you for support, have a principal place of residence with you for the entire year, and are members of your household for the entire year. No coverage is provided if the parent(s) do not meet these requirements.

Enrollment

You (the Employee) are automatically enrolled in this Plan as soon as the Eligibility requirements of the Plan are met.

Enrollment of Spouse, Child(ren) and/or Parent(s)

If you have Dependents when you are first eligible, you may enroll your Eligible Spouse, Child(ren) and/or Parents at the same time you become covered for benefits. Their coverage will be effective at the same time as your coverage. Dependents will be enrolled in the Plan when they meet the eligibility requirements and when you submit the necessary proof for coverage to be effective. If you do not enroll your dependents within 60 days after your coverage begins, you may enroll them late (see Late Enrollment procedures).

At the beginning of each benefit quarter, you will be required to complete an Affidavit about other coverage for your Spouse or Parent and/or Adult Child(ren) covered by the Plan. You will be required to provide information on the Affidavit about the existence of other coverage for coordination of benefits purposes. If the Fund Office does not receive the Affidavit, coverage will be suspended for your Spouse or Parent and/or Adult Child(ren) until the form is received by the Fund Office. If the form is received within 31 days of the beginning of the quarter, coverage will be reinstated retroactive to the beginning of the quarter for which you were required to provide the form. If the form is not received within 31 days of the beginning of the quarter, coverage will be terminated for the quarter and you will not be able to re-enroll your Dependent(s) until the next quarter provided you are still eligible for coverage at that time. If you or any of your dependents obtain other coverage, you are required to submit proof about the other coverage to the Fund Office within 31 days.

In order to cover your Dependents, you must provide the Fund Office with proof of eligibility status. The Fund Office will accept a copy of any of the following documents as proof of eligibility status (and must have the Social Security numbers for your Eligible Spouse, Child(ren) and Parents):

- Spouse / Marriage: copy of the original marriage certificate, copy of original birth certificate, and copy of Social Security card.

- Child / Birth: certified copy of birth certificate and copy of Social Security card.

- Adopted Child / Adoption or placement for adoption: original copy of the court order paper signed by the judge and copy of Social Security card.

- Child under Legal Guardianship: copy of court-appointed legal guardianship documents, original birth certificate, copy of Social Security card, and federal income tax return.

- Step-Children: certified copy of birth certificate, copy of the original marriage certificate and copy of divorce certificate or court order of payment for step-child

- Disabled Dependent Child: Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly relies upon you and/or your spouse for support and maintenance. The plan may require that you show proof of support and maintenance such as a copy of your income tax return showing you claim the child as a Dependent on IRS tax forms in compliance with the IRS Code 152 (a). If your child has a Medicare card, you must submit a copy to the Fund office.

- Parent: Proof that for the entire year, your Parent or Parents are fully dependent upon you for support, have a principal place of residence with you and are members of your household, original birth certificate, copy of Social Security card, and a copy of your tax records showing dependent status.

Special Enrollment

Newly Acquired Spouse and/or Child(ren)

If you are enrolled for individual coverage under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)

Provided you properly enroll, your newborn child will be covered from the date of birth. Adopted newborns will be covered from the date of birth provided the child is placed for adoption with you no later than 31 days after the child is born. Adopted children will be covered from the date of adoption and new spouses (and any step-children) will be covered from the date of marriage.

Provided they are properly enrolled, your adopted Child will be covered from the date that the child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support for the child whom you plan to adopt. If you and your other Dependents are not covered by the Plan at the time you enroll your newborn child, you may also enroll yourself and your other Dependents at the time you enroll your newborn child. However, if a child is placed for adoption with you and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Loss of Other Coverage

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your and/or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Special Enrollment due to Medicaid or a State Children's Health Insurance Program (CHIP)

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. You and your dependents may also enroll in this Plan if you become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after Medicaid or CHIP coverage ends or you and/or your dependents are determined to be eligible for premium assistance.

Requesting Special Enrollment: To request special enrollment or obtain more information, contact the Fund Office at 451 Park Avenue South, 9th Fl., New York, New York 10016 or by calling (212) 684-1586.

Late Enrollment

If you do not enroll your dependents when first eligible for coverage in accordance with the deadlines described in this section, you may enroll them later. However, coverage will not be effective until the first of the month following the date your completed enrollment form (and any required proof) is received by the Fund Office.

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

The Plan will accept a Special Enrollment of the Child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.

Coverage of a Child under a QMCSO will terminate when coverage of the employee-parent terminates, for any reason including failure to pay any required contributions, subject to the Child's right to elect COBRA continuation coverage if it applies. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the employee and all members of the employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the employee.

The QMCSO may also require the Plan to pay Plan Benefits on account of expenses incurred by or on behalf of the Child (ren) covered by the Plan either to the Health Care Provider who rendered the services or to the custodial parent of the Child(ren). If coverage of the Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received an QMCSO, it will pay Plan Benefits on account of expenses incurred by or on behalf of the Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Fund Office.

Termination of Dependent Coverage

Dependent coverage ends on the earliest of the last day of the month in which:

- the Participant's coverage ends; or
- your covered Spouse, Parent or Dependent Child(ren) no longer meet the definition of Spouse, Parent or Dependent Child(ren) as provided in this document; or
- for Dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO; or
- the date Dependent coverage is discontinued under the Plan; or
- the date of the Dependent's death.
- For your spouse and step-children, the date of divorce or legal separation

Extension of Dependent Coverage in the Event of Participant's/Pensioner's Death

Active Participants

Eligible Dependents of a deceased Participant who was covered by the Health Fund for ten or more years will be covered for Dependent benefits for a period of five years or until the earliest of (i) the date of the Participant's death; or (ii) the date the surviving spouse remarries; or (iii) the end of the month a dependent no longer meets the definition of Dependent (e.g., a child turns age 26).

Pensioners

The dependents of a deceased Pensioner who was eligible for benefits at the date of death will continue to be covered for Health Fund benefits as follows:

- Eligible Dependents of a deceased Pensioner who retired on an Early Retirement, Disability Retirement or Regular Pension with at least 10 years but less than 15 Pension Credits under the Iron Workers Local 40, 361 and 417 Pension Plan and was covered by the Health Fund for ten or more years will be covered for Dependent benefits for a period of five years or until the earliest of: (i) the date of the Pensioner's death; or (ii) the date the surviving spouse remarries; or (iii) the end of the month a dependent no longer meets the definition of Dependent (e.g., a child turns age 26).
- Eligible Dependents of a deceased Pensioner who retired on an Early Retirement, Disability Retirement or a Regular Pensioner with at least 15 but less than 25 Pension Credits under the Iron Workers Locals 40, 361 and 417 Pension Plan will be covered for benefits for a period of ten years or until the earliest of: (i) the date the surviving spouse remarries; or (ii) the date the dependent no longer meets the definition of Dependent (e.g., a child turns age 26)
- Eligible Dependents of a deceased Pensioner who retired on a "Age 57 Plus 30" Pension or a Regular Pension with 25 or more Pension Credits under the Iron Workers Locals 40, 361, and 417 Pension Plan will be covered for Dependent benefits until the earliest of the date: (i) the Pensioner's surviving spouse remarries; (ii) the Dependent dies; or (iii) the date the Dependent no longer meets the definition of Dependent (a child turns age 26).

Important Note about COBRA: Eligible Dependents will have the option of electing COBRA continuation instead of receiving Extended Coverage under this provision. If COBRA continuation coverage is not elected within the

required timeframes, Eligible Dependents will no longer have any rights to COBRA continuation. See the COBRA Continuation Coverage section for details on your rights under COBRA coverage.

Family and/or Medical Leave (FMLA)

The Family Medical Leave Act, 29 USC §2601 et seq. provides that if you work for an employer covered by that Act you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own illness. You may also be entitled to unpaid leave to take care of a military service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious illness or injuries as a result of their service. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year.

A covered employer is required to maintain the same health coverage for you on FMLA leave as the coverage that was provided before the leave was taken and under the same terms as if you had continued work. Therefore, an employer covered under FMLA must continue to contribute on your behalf while you are on FMLA leave as though you had been continuously employed. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer. For information on your rights to continue coverage while you are on a FMLA leave, you may contact the Fund Office.

Leaves of Absence for Military Service

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

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

Once the Fund Office receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA. Therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the date the employee stopped working. USERRA continuation coverage operates in the same way

as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage.

For more information about self-payments under USERRA, contact the Fund Office.

After Discharge from the Armed Forces

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

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

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

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

USERRA allows the employee to apply accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. For example, when an employee's eligibility period would normally end, the employee may pay for USERRA coverage under the self-pay rules of this Plan. If the employee does not want to use his accumulated eligibility to pay for USERRA coverage, the employee can choose to freeze his eligibility and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan.

Paid Family Leave (PFL) under New York State Law

The Fund will provide eligible participants with paid family leave under New York's Paid Family Leave (PFL) Law.

An eligible participant may take PFL for the following reasons:

- To provide care for a "covered family member" when the family member has a serious health condition;
- To bond with the employee's child during the first year of birth, adoption, or foster care placement; or
- To assist family members when a covered family member is on active duty or has been notified of an order to resume active duty in the military.

To "provide care" means that the participant is in close and continuing proximity to the family member receiving care, and must be present in the same location as the family member during the leave period. It includes any time you need to travel to obtain medication or arrange care for the family member. It also includes various types of care, such as necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters and personal attendant services.

A "covered family member" is a biological, adoptive, or foster child, the child of the participant's spouse or domestic partner; the employee's spouse or domestic partner; the participant's parent (including parent-in-law, stepparent or guardian while the participant was a child); or grandchild and grandparent of the participant.

A "serious health condition" is an illness, injury, impairment or physical or mental condition that involves in-patient care in a hospital, hospice, or residential healthcare facility, continuing treatment, or continuing supervision by a healthcare provider. It excludes cosmetic treatments unless inpatient treatment is required or complications develop. Similarly, it excludes the common cold, flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, etc., unless complications arise.

"Continuing supervision by a healthcare provider" includes a period of incapacity which is permanent or long term due to a condition for which treatment may not be effective.

The first year following birth, adoption, or foster care placement ("child bonding") generally begins on the date of the child's birth, adoption or foster care placement with the participant and ends after 52 consecutive weeks. It includes time before the actual placement or adoption of a child if an absence from work is required for the placement for adoption or foster care to proceed; and includes counseling sessions, court appearances, meetings with a birth parent's attorney or doctor, and travel to another country to complete an adoption.

Participants may receive either short-term disability or PFL benefits during the post-partum period, but may not receive both benefits at the same time.

Eligibility

Participants whose regular employment schedule is 20 or more hours per week are eligible to take PFL if they have been employed by the same Covered Employer for 26 consecutive weeks. Scheduled vacation, sick days, or other employer-approved absences from work will be counted as consecutive weeks, provided contributions are made to the Health Fund for those absences; however, periods of short-term disability are not counted as weeks of employment for eligibility purposes. Participants whose regular employment schedule is less than 20 hours per week are eligible to use benefits after the 175th day of regular employment with the same Covered Employer.

Participants are not eligible for PFL after termination of employment from the Covered Employer.

Period of Leave and Pay Amount

The length of paid leave and amount of pay during leave is as follows:

Effective Date	Maximum Length of Leave	Maximum Amount of Pay During Leave
January 1, 2018	8 weeks	50% of participant's average weekly wage, but not more than 50% of the state's average weekly wage
January 1, 2019	10 weeks	55% of participant's average weekly wage, but not more than 55% of the state's average weekly wage
January 1, 2020	10 weeks	60% of participant's average weekly wage, but not more than 60% of the state's average weekly wage
January 1, 2021	12 weeks	67% of participant's average weekly wage, but not more than 67% of the state's average weekly wage

Participants will receive a weekly maximum benefit amount of $652.96 for the year 2018.

Job Protection/Reinstatement

PFL is job-protected leave, and participants returning from qualifying leave must be reinstated to the same or comparable position occupied prior to taking PFL, with comparable pay, benefits, and other terms and conditions of employment.

Continuation of Health Coverage

Your coverage under the Health Fund will not be terminated during an approved PFL. The time you are out on PFL will not count toward continuing eligibility, however.

Participant Responsibilities

You must provide at least 30 days' advance notice for PFL if the qualifying event is foreseeable, for example, an expected birth. When less than 30 days' notice is provided in the event of a foreseeable need for leave, the PFL claim may be denied for a period of up to 30 days from the date the notice was provided. When the qualifying event is unforeseeable, you are required to provide notice as soon as practicable.

You will need to file a form requesting PFL. You can obtain a form from the Fund Office. Upon receipt of the form, the Fund Office will send it to the Covered Employer to complete their section.

Required Documentation

You also must provide documentation in support of your Paid Family Leave request.

To justify your request for Paid Family Leave, you will be required to present a certification from the health care provider treating your family member or, if the leave is following birth of a child, the health care provider treating the mother of the child. For adoption and foster care, different types of documentation will be needed. If you are taking Paid Family Leave for a qualifying military event, you will need to present copies of Duty Papers or other supporting documentation.

For Birth:

The birth mother will need the following documentation:

- Birth Certificate, or
- Documentation of pregnancy or birth from a health care provider (includes mother's name and due/birth dates)

A second parent will need the following documentation:

- Birth certificate, or if not available, a voluntary acknowledgment of paternity or court order of filiation; or
- A copy of documentation of pregnancy or birth from a health care provider (includes mother's name and due/birth dates) and a second document verifying the parent's relationship with the birth mother or child.

For Foster Care:

- Letter of placement issued by county or city department of social services or local voluntary agency
- If second parent is not named in documentation, a copy of the letter of placement plus a second document verifying the relationship to the parent named in the foster care placement.

For Adoption:

- Legal evidence of adoption process
- If second parent is not named in legal documents, the second parent must provide a copy of the legal evidence of adoption process and a second document verifying the relationship to the parent named in the document.

For Serious Medical Condition:

- Certification from the Care Recipient's Health Care Provider

For the Military:

- US Department of Labor Military Family Leave Certification (Federal Military Leave Form)
- Copy of Military Duty Papers
- Other documentation supporting the reason for the leave (copy of meeting notice, ceremony details, rest and recuperation orders, etc.)

Correlation with the Federal Family Medical Leave Act (FMLA) and Other Leaves

FMLA leave will run concurrently with PFL, if PFL is taken for a purpose covered by FMLA.

Employees may not receive both PFL and disability benefits for the same period. An employee who is eligible for both disability and PFL benefits may not receive more than 26 weeks of disability and PFL benefits combined during the same 52-consecutive calendar week period.

Taxability

PFL benefits will be taxable non-wage income that must be included in federal gross income.

Questions

Please contact the Fund Office if you have any questions.

CONTINUATION OF COVERAGE (COBRA)

If you and/or your dependents lose health coverage due to a qualifying event, you may be able to continue your coverage under the Plan. Under most circumstances, you, your Dependents, or your survivors will have to pay for the cost of this coverage. Read this section carefully and follow these rules to obtain COBRA coverage. Contact the Fund Office if you have any questions. To be eligible for COBRA coverage, you or your Dependents must be covered by the Plan on the day before the qualifying event occurs. However, children who are born to you or adopted by you (or placed for adoption with you) during your COBRA continuation period will be treated as eligible for COBRA coverage.

If you are eligible for Pension Benefits, please be aware that, when you retire, you have the option of electing COBRA continuation of your active coverage instead of Pension Benefits. If you do not elect COBRA continuation coverage when you retire within the timeframes described in this section, you will no longer have any rights to COBRA continuation coverage, even when you lose your Pensioner Benefits.

However, if your spouse and/or dependent child(ren) who are covered under Pensioner Benefits experience a COBRA qualifying event while receiving Pensioner Benefits (if you get divorced or legally separated, or a child turns age 26, you become entitled to Medicare Parts A or B and lose COBRA coverage), they will be entitled to continue Pensioner Benefits in accordance with COBRA continuation for a period of up to 36 months from the date of the loss of Pensioner benefits.

If you die while covered by Pensioner Benefits, your eligible Dependents will be offered the option of electing COBRA continuation or the option of continuing Pensioner Benefits in accordance with the *Extension of Dependent Coverage in the Event of a Participant's/Pensioner's Death* if the eligibility requirements are met. If your Dependents do not elect COBRA continuation coverage within the timeframes described in this section, they will no longer have any rights to COBRA continuation coverage, even when they lose coverage. If the requirements for the Extension of Dependent Coverage are not met, your eligible Dependents will be eligible for COBRA continuation for a period of up to 36 months from the date of the your death.

Alternatives to COBRA: Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov or call 1-800-318-2596. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Background Information

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer employees and their covered Dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the Plan would otherwise end.

If you or your Spouse and/or Dependent children are covered under the medical and/or dental Plan, you and/or your Dependents can continue coverage for a time if coverage ends for one of several reasons , known as "qualifying events", even if your Dependents are already covered by another group health plan or Medicare.

Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying Event *	Maximum Periods of Continuation Coverage for:		
	Employee	**Spouse**	**Covered Children**
Employee is terminated (for reasons other than gross misconduct)	18 months	18 months	18 months
Employee experiences a reduction in hours worked (making employee ineligible for the same coverage)	18 months	18 months	18 months
Employee Dies	N/A	36 months	36 months
Employee becomes Divorced or Legally Separated	N/A	36 months	36 months **(step-children only)**
Employee becomes Entitled to Medicare	N/A	36 months	36 months
Covered Child loses Eligibility Status	N/A	N/A	36 months

* To be considered a "Qualifying Event," the event must cause a loss of coverage under the Plan.

When a Spouse or Covered Child Must Notify the Plan of a Qualifying Event

In order for a Spouse or Child to be entitled to continue coverage, the employee, Spouse or covered Child must **notify the Plan within 60 days of the:**

- Date of loss of coverage due to the death of the employee;
- Date of loss of coverage due to divorce or legal separation from the employee; or
- Date of loss of coverage due to child no longer meeting the definition of "dependent child".
- The date of a second qualifying event (or date of when coverage would be lost due to second qualifying even, if later).

You must also notify the Plan when a qualified beneficiary is determined by the Social Security Administration to be disabled during a COBRA coverage period or when the Social Security Administration determines that a qualified beneficiary is no longer disabled. See the section below entitled, "Entitlement to Social Security Disability Income Benefits."

Notification must be made in writing to the Fund Office. You need to include the qualifying or second qualifying event, name of the Participant, name of Dependent, and the date of the qualifying/second qualifying event (or date of disability determination). You also need to provide the supporting documentation (for example, copy of the Divorce Decree or Death Certificate).

If the Plan does not receive written notice of any such event within that 60-day period, the Spouse and/or Child(ren) will not be eligible for COBRA continuation coverage. You must send this notice to the Fund Office.

Unavailability of coverage. If you or your enrolled dependent has notified the Plan in writing of your divorce, your legal separation or a child's loss of dependent status, or a second Qualifying Event, but you or your enrolled dependent is not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same time frame the Plan follows for election notices.

Notice That You or Your Dependent(s) Are Entitled to Continuation Coverage

The Plan will send you and your Dependents an Election Notice when your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Plan is notified on a timely basis that you died, divorced or were legally separated, enrolled in other coverage, or that a covered Child lost Eligibility status. The Election Notice will explain your right to continue health care coverage under the Plan. You and/or your Dependent(s) will then have 60 days to apply for COBRA continuation coverage. If you and/or they do not apply within that time, health care coverage will end as of the last day of the calendar quarter in which the qualifying event occurs.

Coverage That Will Be Provided if You Elect Continuation Coverage

If you and/or your Dependent(s) choose COBRA continuation coverage, the Plan is required to provide coverage that is identical to the current coverage under the medical and/or dental plan that is provided for similarly situated employees and their family members. You will have a choice of full coverage, including hospitalization, comprehensive medical, dental, optical and prescription drug coverage or medical coverage only, which excludes dental and optical coverage.

If during the period of COBRA continuation coverage, you marry, have a newborn child, or have a child placed with you for adoption, that Spouse or Child may be enrolled for coverage for the balance of the period of COBRA continuation coverage on the same terms available to active employees. Enrollment must occur no later than 31 days after the marriage, birth or placement for adoption. A child born or placed for adoption with you while you are on COBRA continuation coverage (but not a spouse that you marry while you are on COBRA continuation coverage) will have all the same COBRA rights as your spouse or Child(ren) who were covered by the Plan before the event that resulted in your loss of coverage. Otherwise, the same rules about Eligibility status and qualifying changes in family status that apply to active employees will apply to those Dependent(s). Adding a spouse or Child may cause an increase in the amount you must pay for COBRA continuation coverage. If during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to you and/or your Dependent(s).

Extension of COBRA Continuation Coverage Period Due to a Second Qualifying Event

If your continuation coverage is for a maximum period of 18 months, and during that period, another qualifying event (i.e., your death, divorce or legal separation, or entitlement to Medicare) takes place that would otherwise entitle a Spouse or Child to a 36-month period of continuation coverage, the 18-month period will be extended for that Spouse or Child. The total period of coverage for any Spouse or Child will never exceed 36 months from the date of the first qualifying event. For example, if you terminated employment and elected COBRA continuation coverage for 18 months for you and your covered Spouse and/or Child(ren), and died during that 18-month period, the continuation coverage for your Spouse and/or Child(ren) could be extended for the balance of 36 months from the date your employment terminated.

However, if you become entitled to COBRA continuation coverage because of termination of employment or reduction in hours worked that occurred less than 18 months after the date you became entitled to Medicare, your Spouse and/or Child(ren) would be entitled to a 36-month period of COBRA continuation coverage beginning on the date you became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date you become entitled to Medicare, your Spouse and/or Child(ren) would be entitled to COBRA continuation coverage for a 36-month period beginning on the date you became entitled to Medicare, although your coverage would be limited to 18 months from your termination.

In all of these cases, you must make sure that the Fund Office is notified in writing of the second qualifying event within 60 days of the later of the second qualifying event or the loss of coverage due to the second qualifying event.

If the Plan does not receive written notice of the second qualifying event within that 60-day period, the Spouse and/or Child(ren) will not be eligible for COBRA continuation coverage. You must send this notice to the Fund Office.

If you die after having been covered by the Health Fund for ten or more years and while your dependents are on a COBRA extension, your eligible Dependents will have the choice of being covered under the *Extension of Dependent Coverage* (as described on page xx) for a period of five years beyond the date benefits would have normally terminated or electing to extend COBRA continuation under this provision. If your Dependents do not elect to extend COBRA continuation coverage within the timeframes described above, they will no longer have any rights to COBRA continuation coverage, even when they lose coverage.

Entitlement to Social Security Disability Income Benefits

If you, your Spouse or any of your covered Child(ren) are entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage; and

- The disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and

- The Plan is notified by you or the disabled covered person that the determination was received:

  - No later than 60 days after it was received; and

  - Before the 18-month COBRA continuation period.

This extended period of COBRA continuation coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled individual becomes entitled to Medicare.

What You Must Pay for COBRA Continuation Coverage

You, your covered Spouse and/or your covered Child(ren) will have to pay up to 102% of the full cost of the coverage during the COBRA continuation period. However, any individual or family whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA continuation coverage.

The amount you, your covered Spouse and/or your covered Child(ren) must pay for your COBRA continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amounts due starting with the date you elect continuation coverage. If you do not make your first payment for COBRA in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. Payments for subsequent months are due on the first day of the month for which coverage is being continued. If payment of the amounts due is not received by the end of the applicable grace period, COBRA continuation coverage will terminate.

Grace Period for Payments. Although payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan. If you pay the premium later than the first day of the month to which it applies, but before the end of the grace period, your coverage will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the coverage period) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Termination of COBRA Continuation Coverage

COBRA will continue for the maximum period. However, COBRA continuation coverage may be terminated earlier than the maximum period if:

- The Plan no longer provides any medical or dental coverage to any of its similarly situated employees;
- You do not pay the applicable premium for your COBRA continuation coverage on time;
- The covered person becomes entitled to Medicare after election of COBRA; or
- The covered person becomes covered under another group health plan after election of COBRA.

If any covered person becomes entitled to Medicare, the COBRA continuation coverage of that person ends, but the COBRA continuation coverage of any covered Spouse or Child of that covered person will not be affected.

Other Information About COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA, as of the effective date of those changes.

COBRA Questions or To Give Notice of Changes in Your Circumstances

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

Keep the Plan Informed

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Conversion of Insurance

You have no conversion rights for medical, hospital or dental, drug benefits. You have a right to conversion for life and accidental death & dismemberment benefits. The Hartford will provide this information when you

terminate your active coverage. You generally have 30 days to convert. You may also contact the Fund Office if you want to convert your life insurance to an individual direct payment type of policy. The Fund Office can furnish you with the necessary information and the required forms.

Employee Penalties

If you in any way misrepresent your employment, as determined by the Trustees, you will lose eligibility for all benefits incurred for yourself and your Dependents for the six-month period following the Trustees' discovery and notification to you of such misrepresentation or fraud. However, claims incurred before this date or periods of hospitalization wherein the confinement date was initiated before this date will be honored under the Plan provisions.

Change in Family Status

Once your Plan coverage becomes effective, it is your responsibility to promptly notify the Fund Office of any of the following changes.

- Marriage,
- Birth or adoption of a child,
- Death in the family,
- Divorce or legal separation,
- Change of address,
- Dependent Eligible Covered Child attaining age 26, or
- Desire to change your beneficiary.

No Medical Examination

No medical examination is required in order for you or your Dependents to obtain this coverage. You and your Dependents will be covered by the Plan without medical examination and regardless of your age and physical condition, provided you meet all the eligibility requirements, including proper enrollment.

LIFE INSURANCE BENEFITS

Eligibility

You are eligible for life insurance coverage after you have worked at least 1,000 hours in covered employment within a 12-month period. If you retire under the Rules and Regulations of the Iron Workers Locals 40, 361 & 417 Pension Fund as a Regular or Early Retirement Pension with at least 15 Pension Credits or Age 57 Plus 30-Year Service Pensioner you are also eligible for a life insurance coverage.

In the event of your death from any cause, on or off the job, while you are covered and upon the Fund's receipt of complete proof of death, your named beneficiary will be entitled to receive a death benefit. For employees, the amount that will be paid to your beneficiary will equal $50,000. For retirees, the amount that will be paid to your beneficiary will equal $4,000. The life insurance benefit is provided through The Hartford Life Insurance Company.

Naming A Beneficiary

You may name anyone you wish as your beneficiary by filing the appropriate form at the Fund Office. Further, you may name more than one beneficiary to receive the proceeds of your Life Insurance coverage. You can change your beneficiary or beneficiaries at any time by filing a new form. The beneficiary on file at the Fund Office at the time of your death is the one who will receive the proceeds of your life insurance coverage.

If you have not designated a beneficiary or if your beneficiary dies before you, the death benefit will be paid to the first surviving person or persons, as follows: your Spouse; if you have no spouse or your Spouse has died, payment will go to your children in equal shares; and if there are no children, payment will be made to your parents in equal shares, if your parents have not survived you, to your brothers and sisters in equal shares. If payment cannot be made to any of the indicated categories, the insurer will pay the death benefit to your estate.

If any beneficiary or other payee is a minor, or someone not able to give a valid release for payment, the insurer will pay the benefit, as permitted by state law, to the guardian of your beneficiary's estate; the custodian of the beneficiary's estate or your beneficiary's legal guardian. If there is no legal guardian, the insurer may pay the benefit to a person(s) or institution that has, in the insurer's opinion, custody and principal support of that beneficiary.

Form of Payment

Benefits will be paid as soon as the necessary proof to support the claim is received. Any death benefit for loss of life will be paid in accordance with the beneficiary designation. Payment will be made in one sum.

If your beneficiary is a minor or, in The Hartford's opinion, legally unable to give a valid release for payment of any life benefit coverage, the benefit will be payable to the guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

Permanent and Total Disability Benefit

In the event you become disabled as the result of a serious illness or injury, you may be eligible for a permanent and total disability benefit. A physician must determine that you are permanently and totally disabled. You must also meet the conditions set forth below.

You will be considered permanently and totally disabled if your illness or injury prevents you from:

- Working at your own job or any other job for pay or profit; and

- Being able to work at any reasonable job. A "reasonable job" is any job for pay or profit which you are, or may reasonably become, qualified for by education; training, or experience.

You must meet all of the following criteria to qualify for this benefit:

- You must be insured under this plan when you stop active work due to your illness or injury;
- You must be under age 60 when you stop active work; and
- You must be absent from active work for 9 consecutive months without interruption.

Stopping active work means the date you are no longer physically at your job performing the duties of your job.

The conversion privilege will be available at any time during this period for the amount of your insurance.

You must give The Hartford a written notice of claim for this extended benefit. The Hartford must receive your notice within 24months from the date you stop active work. If your written notice is not received within 24 months of the date you stop active work, you will not be eligible for this benefit extension. Notice of claim needs to be given to The Hartford during your lifetime and during the period of Total Disability. Failure to give such notice will not invalidate or reduce any claim if such notice is given as soon thereafter as reasonably possible.

You must furnish proof of your permanent and total disability upon request by The Hartford. The Hartford also has the right to have a physician examine you, at no cost to you. The Hartford will use the information to help determine if you are permanently and totally disabled.

Amount of Benefit Payable

Your extended benefit will be equal to the amount you were insured for on the date your permanent and total disability began. However, coverage will be reduced as described in the section called “When Life Insurance Coverage Amounts are Reduced.”

Failure to provide proof of death or disability within the required time will not invalidate or reduce any claim if it was not reasonable possible to do so, provided such proof is given as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

This benefit extension ends when the first of the following occurs:

- The date The Hartford sends you a request (at the most recent address in its records) for:
- An exam or proof that you are still permanently and totally disabled; and
- You do not go for the exam or provide proof of your continued disability within 31 days of that date.
- The date you are able to work at any reasonable job;
- The date you begin working at any job for pay or profit.

After your insurance has been extended continuously for 2 years, The Hartford will not require an exam or proof more than once in a 12 month period.

You will be eligible to convert to an individual life insurance policy, as if your employment had ended, when this benefit extension ceases. However, the amount of life insurance which you may convert will be reduced by the amount for which you become eligible or insured under any group policy within 45 days after this benefit extension ceases.

Extended Death Benefit

The Hartford will pay your beneficiary the amount of life insurance that may be extended under the permanent and total disability feature. Your beneficiary must give The Hartford proof that all of the following apply:

- Your life insurance premium payments ended: (a) while you were absent from work due to illness or injury; and (b) before The Hartford received your written notice of claim for the permanent and total disability benefit;
- You were continuously absent from active work until the time of your death;
- Your death occurred no later than 12 months after premium payments stopped;
- You would have qualified for the permanent and total disability benefit except that:
  - You were not absent from work for 9 consecutive months without interruption; or
  - The Hartford had not yet received or approved your claim for the permanent and total disability benefit.

In the event the coverage under the group policy is discontinued, the Extended Death Benefit will continue for the same duration and under the same terms, as long as these conditions apply.

Your beneficiary must give The Hartford written notice of your death within 12 months of your death. If The Hartford does not receive the notice, The Hartford will not be obligated to pay this benefit.

When The Hartford approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of The Hartford's obligations. After you cease active work with your policyholder due to illness or injury, you must ensure that The Hartford and your policyholder have current beneficiary information on file. If current beneficiary information is not sent to The Hartford in writing, and, your policyholder has discontinued the Plan with The Hartford, The Hartford will have the right to rely on the most recent beneficiary information that The Hartford has on file at the time of claim. The Hartford will be fully discharged of its duties as to any payment made.

Accelerated Death Benefit

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. You should consult with your counsel or tax advisor before requesting an accelerated death benefit. The plan's Accelerated Death Benefit feature allows you to receive a partial life insurance benefit if you are diagnosed with a terminal illness.

The Amount of Accelerated Death Benefit You can request up to the Accelerated Death Benefit percentage of the life insurance that is currently in effect for you. The amount you request cannot be less than the lower of 25% the life insurance amount in effect on that person or $50,000.

You may request and receive an Accelerated Death Benefit under this plan only once on your own behalf.

Requesting an Accelerated Death Benefit

To request the Accelerated Death Benefit, you must complete and submit a request form to The Hartford. The request form must include:

- A statement of the amount requested; and
- A physician's statement verifying that you are suffering from a non-correctable terminal illness, and providing the following information:
- All medical test results;
- Laboratory reports; and
- All supporting documentation and information on which the physician's statement is based.

Submit the form to The Hartford. The Hartford may, at its own expense, require you to submit to an independent medical exam by a physician it chooses. The Hartford will not process your Accelerated Death Benefit request until the exam has been completed and The Hartford has received the results.

The Hartford May Refuse Your Accelerated Death Benefit Request:

The Hartford may stop processing your Accelerated Death Benefit request or refuse your Accelerated Death Benefit request if:

- The group policy terminates coverage for your eligible class before you submit your Accelerated Death Benefit request (even if all or part of your life insurance coverage continues for any reason);
- All of your life insurance coverage terminates under the group policy for any reason before you submit your Accelerated Death Benefit request; or
- You die before The Hartford issues the Accelerated Death Benefit payment.

Accelerated Death Benefit Payment

If your request is approved, The Hartford will pay you the Accelerated Death Benefit in a lump sum. The amount will be reduced by interest charges that would have accrued on the requested amount.

- The interest charge is equal to the sum of daily interest that would have accrued on that amount during the Accelerated Death Benefit months which begins on the date the Accelerated Death Benefit is paid.

Important Reminder The interest rate used to calculate the interest charge will not exceed the current yield on 90-day Treasury bills on the date the Accelerated Death Benefit payment is requested.

Effect of an Accelerated Death Benefit Payment on:

- Your Life Insurance Benefit

  The amount of life insurance covering you will be reduced by the amount of the Accelerated Death Benefit payment, plus the interest charges.

- Premiums

  Premiums will be adjusted to reflect any amount of benefits that has been accelerated.

- Life Conversion

  An Accelerated Death Benefit payment affects the amount of life insurance you are eligible to convert to an individual policy. The converted amount will be limited to the reduced amount of life insurance after the Accelerated Death Benefit payment.

Extended Benefits Under the Permanent and Total Disability Feature

You may apply for an Accelerated Death Benefit payment if you have qualified for an extension of your life insurance because of your permanent and total disability, as long as you have not previously requested and received an Accelerated Death Benefit payment. All of the terms of the Accelerated Death Benefit feature will apply to an Accelerated Death Benefit request you make while your life insurance is being extended under the terms of the permanent and total disability provision

Payment of Benefits

Benefit payments are made in a lump sum unless you have elected an installment method which has been agreed to by The Hartford. If you do not select an installment method prior to your death, your beneficiary has the right to elect either:

- A lump sum payment; or
- An installment option
- Before any payment is made.

The Hartford will give your beneficiary additional information about payment options when a claim is filed. The method of payment allowed will be those offered by The Hartford at the time the election is made.

The Hartford will issue a benefit payment to your beneficiary as soon as the necessary written proof supporting the death claim is received.

Claims of Creditors

To the extent allowed by law:

- Your Accelerated Death Benefit payment is exempt from any legal or equitable process for your debts; and
- You are not required to request an Accelerated Death Benefit in order to satisfy claims of creditors.

Filing A Claim and Proof of Death

If you die while covered, proof of your death should be given to the Fund Office promptly. Proof of your death is a certified copy of your death certificate and any other documentation the Plan Administrator may require to establish the validity of the claim for this benefit.

This section and the next section outline the insured life insurance and accidental death and dismemberment benefits provided through the The Hartford Life Insurance Company. Where these sections deviate from the certificate of coverage and summary of benefits produced by the The Hartford Life Insurance Company, the The Hartford Life Insurance Company documents will prevail. Contact the Fund Office for a copy of insurance coverage documents.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Overview of Accidental Death and Dismemberment (AD&D) Coverage

This Plan pays a benefit if, while insured, you suffer a bodily injury caused by an accident; and if, within 365 days after the accident and as a direct result of the injury, you lose:

- Your life.
- A hand, by actual severance at or above the wrist joint.
- A foot, by actual severance at or above the ankle joint.
- An eye, involving irrecoverable and complete loss of sight in the eye.
- Your speech or hearing; the loss must be total and deemed permanent.
- Your thumb and index finger of same hand, by actual severance of entire digit.
- Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months, unless an attending physician states otherwise.

Loss of life due to exposure to natural or chemical elements will be deemed to be accidental if the exposure was a direct result of an accident.

If:

- you disappear as a direct result of the accidental disappearance, wrecking, or sinking of the conveyance in which you were an occupant; and
- there is no contrary evidence about the circumstances of your disappearance within one year of the accident;
- your disappearance will be deemed an accidental death.

This Plan also pays a benefit if, while insured, a person suffers a bodily injury in an accident and if, as a direct result of the accident suffers a full thickness third degree burn caused by direct contact with a chemical, fire, steam, water or heat (except sunburns) or, within 30 days after the accident and as a direct result of the injury, you are stricken with one of the following forms of paralysis:

- Quadriplegia - the entire and irrecoverable paralysis of both upper and lower limbs.
- Paraplegia - the entire and irrecoverable paralysis of both lower limbs.
- Hemiplegia - the entire and irrecoverable paralysis of the upper and lower limbs on one side of the body.
- Uniplegia - the entire and irrecoverable paralysis of one limb.

A limb means the entire arm or leg.

Coma – The Hartford will pay a monthly benefit on your behalf provided you are continually comatose for at least 30 consecutive days. Proof that you are comatose must be submitted to The Hartford no later than 60 days after the date you become comatose.

Benefit

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS		
Your Loss or Condition	**Benefit Payable**	**Payable To**
Life	$50,000	Your Beneficiary
Both Hands	$50,000	You
Both Feet	$50,000	You
Both Eyes	$50,000	You
Both Hearing and Speech	$50,000	You
Quadriplegia	$50,000	You
Third Degree Burns on 75% of Your Body	$50,000	You
Hearing	$25,000	You
Speech	$25,000	You
One Hand	$25,000	You
One Foot	$25,000	You
One Eye	$25,000	You
Paraplegia	$25,000	You
Hemiplegia	$25,000	You
Third Degree Burns on 50% to 74% of Your Body	$25,000	You
Loss of Thumb and Index Finger of the Same Hand	$12,500	You
Uniplegia	$12,500	You

The following benefit is payable if you become comatose:

The first monthly benefit will be payable on the first day of the month following the date you have been continually comatose for at least 30 days.

The monthly benefit is the Coma Benefit Percentage (5% of the full benefit, which is $50,000) less any benefit amount paid or payable under this benefit section for any loss you suffer as a direct result of a bodily injury caused by the same accident. The monthly benefit is payable for 11 months. The full Principal Sum less any benefit amount paid or payable under this benefit section because of the same accident will be payable after you have been continually comatose for 12 months.

No more than the full Principal Sum is payable for all losses resulting from the same accident.

The monthly benefit is payable for as long as the coma continues, until the earliest to occur of:

- failure to have any required exam;
- failure to give proof that the coma continues;
- the date the full Principal Sum is paid under this benefit section;
- the date you are no longer comatose, by death, recovery, or any other change of condition, as certified by a physician; or
- termination of the group policy.

The Hartford will have the right to require proof of the continuation of the coma. The Hartford, at its own expense, also has the right to examine you while the coma continues. The Hartford will not request an exam or proof more often than twice in a 12 month period. A physician's certification will be required before the final payment is made to your beneficiary.

If you become comatose and qualify for a related benefit, your monthly benefit is payable to your named beneficiary. No benefit will be payable if:

- no named beneficiary survives you; or
- no beneficiary has been named; and
- no immediate family member to whom the benefit may be paid, at The Hartford's discretion, survives you. Immediate family members are: your spouse, your children, your parents, and your brothers and sisters.

If benefits are to be paid as a result of your comatose state, and if the monthly payments are less than $20 each, the payments will be paid in one lump sum on the first day of the month following the date you have been continually comatose for 12 months.

No more than the full Principal Sum ($50,000) is payable for all losses listed above resulting from one accident.

Total Disability Benefit

If you become totally disabled as defined below because of an accident of the type covered by this benefit section and that disability is continuous from the date of the accident until your death, The Hartford will pay your beneficiary the amount of your Principal Sum if all of the following are true:

- You are not able to work at your own job.
- You are not able to work at any other job for pay or profit.
- You are under age 60 at the time of the accident.
- You die while this group policy is in effect.
- Your Policyholder continues to make premium payments for your coverage.

If a death benefit is payable, it will be reduced by any other benefit which is payable under this benefit section because of the same accident.

Written notice of your death must be given to The Hartford at its Home Office within 12 months of your death. If it is not reasonably possible to meet this deadline for giving notice, the benefit will still be payable if written notice is given as soon as reasonably possible. Otherwise, The Hartford will not have to pay this benefit.

Additional Accidental Death Benefits

The following benefits will be payable if, while insured, a person suffers a bodily injury caused by an accident and if, within 365 days after the accident, he or she suffers a loss of life solely and as a direct result of the accident.

Passenger Restraint and Airbag Benefit

If a covered loss of life occurs solely and as a direct result of an accident involving a motor vehicle while the person:

- is an occupant of the motor vehicle; and
- at the time of the accident, is properly using a passenger restraint; and
- if the driver has, at the time of the accident, a valid driver's license;

A Passenger Restraint Benefit will be payable. If an airbag is also activated as a result of the same accident, an Airbag Benefit will be payable if the motor vehicle's airbag system is not effective in helping save the person's life it was designed to protect. Verification of the actual use of the passenger restraint and activation of the airbag system, if applicable, at the time of the loss must be part of an official report of the accident or certified, in writing, by investigating officer(s).

No Airbag Benefit will be payable unless a Passenger Restraint Benefit is paid.

Education Benefit for Your Dependent Child

If you suffer a loss of life solely and as a direct result of an accident, an Education Benefit is payable on behalf of each Dependent Child as defined below.

The Education Benefit will be payable in annual installments until the earliest to occur of:

- four years from the date of your death; or
- the date no dependent qualifies as a Dependent Child, as defined below; or
- the date that satisfactory proof of dependent eligibility status is not provided to The Hartford within 30 days of a request for it; or
- discontinuance of the group policy.

The first Education Benefit will be paid when:

- your Principal Sum becomes payable; and
- The Hartford receives written proof that the Dependent Child is attending school on a regular basis.

Education Benefits will be paid on each anniversary of the first Education Benefit, provided The Hartford receives written proof that the Dependent Child is attending school on a regular basis.

A Dependent Child means a child who is:

- your biological child; or
- your adopted child; or
- your stepchild; or
- any other child you support that lives with you in a parent-child relationship;
- and, for the purposes of this benefit, is an unmarried, full-time student and
  - is attending school, up to and including the last grade of high school; or
  - is under the age of 23, and
    - attending college or trade school on a regular basis at the time of your death; or
    - enrolls in college or trade school within 365 days after the claim has been approved.

The Education Benefit will be payable to the Dependent Child if that child has attained the age of majority. Otherwise, the Education Benefit will be payable to the guardian of the estate of the minor, or to the Custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law. If on your death there is no surviving Dependent Child, an Education Benefit will be payable in a lump sum to your named beneficiary.

Education Benefit for Your Spouse

An Education Benefit will be paid to your surviving spouse for costs incurred, as a result of your death, towards employment training if your spouse has enrolled for the purpose of obtaining or supplementing an independent source of income. Written proof of your spouse's enrollment in an employment training program must be received within 365 days after the claim has been approved.

The Education Benefit will be payable in annual installments until the earliest to occur of:

- four years from the date of your death; or
- the date that satisfactory proof of dependent eligibility status is not provided to The Hartford within 30 days of a request for it; or
- discontinuance of the group policy.

The first Education Benefit will be paid when:

- your Principal Sum becomes payable; and
- The Hartford receives written proof that your spouse is enrolled in an employment training program.

Education Benefits will be paid on each anniversary of the first Education Benefit provided The Hartford receives written proof that your dependent spouse is enrolled in an employment training program.

The Education Benefit will be payable to your surviving spouse, regardless of beneficiary for your Life Insurance amount. If you do not have a surviving spouse, an Education Benefit will be payable in a lump sum to your named beneficiary.

Child Care Benefit

If you suffer a loss of life solely and as a direct result of an accident, a Child Care Benefit may be payable with respect to any Dependent Child as defined below. If the Dependent Child is enrolled in a legally licensed child care center, the Child Care Benefit is payable in annual installments until the earliest to occur of:

- four years from the date of your death; or
- the date no dependent qualifies as a Dependent Child, as defined below; or
- the date that satisfactory proof of dependent eligibility status is not provided to The Hartford within 30 days of a request for it; or
- discontinuance of the group policy.

The first Child Care Benefit will be paid when:

- your Principal Sum becomes payable; and
- The Hartford receives written proof that the Dependent Child is enrolled in a legally licensed child care center.

Child Care Benefits will be paid on each anniversary of the first Child Care Benefit, provided The Hartford receives written proof that the Dependent Child is attending a legally licensed child care center.

For purposes of this benefit, a Dependent Child means a child who is under age 13 and is enrolled in a legally licensed child care center on the date of the accident or subsequently enrolled in a legally licensed child care center within 90 calendar days after the date the claim is approve and is either:

- your biological child; or
- your adopted child; or
- your stepchild; or
- any other child you support who lives with you in a parent-child relationship.

The Child Care Benefit will be payable to the guardian of the estate of the minor, or to the Custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law. If on your death

there is no surviving Dependent Child, a Child Care Benefit will be payable in a lump sum to your named beneficiary.

Repatriation of Remains Benefit

This Plan pays a Repatriation of Remains Benefit for the actual expenses incurred to prepare a person's body for transportation to a mortuary if, as a direct result of an accident for which a benefit is payable under this section, he or she suffers loss of life while outside a 200 mile radius from his or her principal place of residence.

SCHEDULE OF ADDITIONAL ACCIDENTAL DEATH BENEFIT MAXIMUMS	
Your Loss or Condition	**Benefit Payable**
Passenger Restraint Benefit Maximum	$10,000
Airbag Benefit Maximum	$5,000
Education Benefit Maximum for Each Dependent Child	5% of your Principal Sum ($50,000) not to exceed $5,000 per year per child for up to 4 years
Education Benefit Maximum for Your Spouse	5% of your Principal Sum ($50,000) not to exceed $5,000 per year per child for up to 4 years
Child Care Benefit Maximum for Each Child	3% of your Principal Sum ($50,000) not to exceed $2,000 per year per child for up to 4 years
Repatriation of Remains Benefit Maximum	$5,000

Limitations

This coverage is only for losses caused by accidents. No benefits are payable for a loss caused or contributed to by:

- A bodily or mental infirmity.
- A disease or bacterial infection.*
- Medical or surgical treatment.*
- Suicide or attempted suicide.
- An intentionally self-inflicted injury.
- A war or any act of war (declared or not declared).
- Commission of or attempt to commit a felony.
- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol.

- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo).

* These do not apply if the loss is caused by:

- An infection which results directly from the injury.
- Surgery needed because of the injury.
- Medical malpractice.

The injury must not be one which is excluded by the terms of this section.

Naming Your Beneficiary

You may name anyone you wish as your beneficiary by filing the appropriate form at the Fund Office. Further, you may name more than one beneficiary to receive the accidental death benefit, in which case the benefit will be split evenly among them. You can change your beneficiary or beneficiaries at any time by filing a new form. The beneficiary on file at the Fund Office at the time of your death is the one who will receive the accidental death benefit. For further information regarding naming your beneficiary see the procedures for naming your beneficiary under the “Life Insurance Benefit” section of this document.

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Policyholder will notify The Hartford of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Policyholder will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Policyholder, but not beyond 12 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Policyholder, but not beyond the end of the policy month after the policy month in which the absence started. The term "policy month" is defined elsewhere in the group contract. See your Policyholder for this definition.

In figuring when employment will stop for the purposes of termination of any coverage, The Hartford will rely upon your Policyholder to notify The Hartford. This can be done by telling The Hartford or by stopping premium

payments. Your employment may be deemed to continue beyond any limits shown above if The Hartford and your Policyholder so agree in writing.

If you cease active work, ask your Policyholder if any coverage can be continued.

Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Policyholder.

- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Policyholder or, if you prefer, from the Home Office of The Hartford.

Your Policyholder hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

Reporting of Claims

A claim must be submitted to The Hartford in writing. It must give proof of the nature and extent of the loss. Your Policyholder has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Otherwise, late claims will not be covered.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. Any death benefit for your loss of life will be paid in accordance with the beneficiary designation. The payment will be made in one lump sum.

All benefits are payable to you.

Any unpaid balance will be paid within 30 days of receipt by The Hartford of the due written proof.

The Hartford may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Filing an Appeal of an Adverse Benefit Determination

Accidental Death and Personal Loss Coverage Claims

You may request a review of the denied claim. You will have 60 days following receipt of an adverse benefit decision to appeal the decision. The request must be submitted, in writing, and include your reasons for requesting the review. Submit your request to the office of the The Hartford Life Insurance Company to which you submitted your initial request for benefit payment. You will be notified of the decision not later than 60 days after the appeal is received. If an extension of time for processing the appeal is needed, the time period may be extended up to an additional 60 days, in which case you will be notified prior to the end of the first 60 day period. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Office.

Claim Procedures

Your booklet-certificate contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means your legal spouse or adult child, or a person you authorize, in writing, to act on your behalf. In addition, the Plan will recognize a court order giving a person authority to submit claims on your behalf.

Filing Accidental Death and Personal Loss Coverage Claims under the Plan

You will be notified of an adverse benefit determination not later than 90 days after the Plan's receipt of the claim. This time period may be extended up to an additional 90 days due to special circumstances. In that case, you will be notified of the extension before the end of the initial 90-day period. Notice of the extension will explain the special circumstances requiring the extension and the date by which a decision is expected.

WEEKLY DISABILITY BENEFITS

Workers' Compensation and Occupational Disease Law benefits are provided by your employer and not the Health Fund. You are covered for this benefit from your first day of employment.

The Plan's weekly disability benefit will be payable to you if, while covered under the Plan, you become totally disabled and unable to work because of a non-occupational accident or sickness. This benefit is insured through The Hartford. A member is not eligible for Weekly Disability Benefits for any week that the member is eligible for benefits under the IMPACT Off-the-Job Accident Program (see the next section for more information about "IMPACT Off-the-Job Accident Program").

Benefits will begin as of the 8th day of disability due to an accident or sickness provided, however, if benefits are paid for three or more consecutive weeks, then benefits shall also be payable with respect to the waiting period. Benefits may continue for any one period of total disability up to a maximum of 26 weeks.

Successive periods of total disability separated by fewer than 14 days of continuous active employment shall be considered as one continuous period of total disability unless they arise from different and unrelated causes provided you have earned wages during such 14 day period with the employer who was your employer immediately preceding the first period of total disability.

You do not have to be confined to your home to collect benefits, but you must be under the care of a physician.

For disabilities arising out of pregnancy or resulting from childbirth, abortion or miscarriage, weekly benefits will be provided in the same way as all other disabilities covered under this provision in accordance with New York state requirements.

The Amount of Your Weekly Disability Benefits

The weekly amount is $300 not to exceed 66 2/3% of average weekly earnings when combined with any other state or group insurance program. For any period of disability that is less than one week in duration, the benefits for each day of disability for which benefits are payable shall be one-seventh of the corresponding weekly benefit amount, multiplied by the number of days.

Filing A Claim for Weekly Disability Benefits

In the event that you become disabled such fact should be reported to the Fund Office within 30 days from the commencement of disability so that a claim form may be secured.

The claim form must be fully completed by all parties called for and submitted to the Fund Office as promptly as possible, but in no event more than 90 days after the start of disability. Improperly completed forms may cause a delay in the payment of your claim.

Benefits will be paid for the period covered by the first claim form for up to two weeks. If disability continues beyond two weeks, intermediate claim forms must be filed every other week.

NOTE: In no event will any benefit be paid under this section on any claim for treatment of an Illness or Injury that is work-related. If a determination is made under a workers' compensation program that the Illness or Injury is not work-related, a benefit may be payable under this section on a claim for treatment of the Illness or Injury, subject to all Plan provisions, limitations and exclusions.

Impact Off-The-Job Accident Program

Effective for injuries occurring on and after January 1, 2015, the Ironworker Management Progressive Action Trust (IMPACT) Off-the-Job Accident plan can aid individual iron worker members with a short term disability caused by an off the job accident.

The amount of the benefit is the lesser of (1) $800.00 or (2) 66.67% of weekly earnings. The program requires a one-week waiting period before benefit disbursement with a maximum benefit duration of 6 weeks.

The program supplements the Weekly Disability Benefits described in the prior section, and it is important to note that a member is not eligible for Weekly Disability Benefits for any week that the member is eligible for benefits under the IMPACT Off-the-Job Accident Plan.

Please direct all claim related questions to the Fund Office.

VACATION BENEFITS

Eligibility for Vacation Benefits

You are eligible for vacation benefits as soon as your Employer begins making vacation benefit contributions on your behalf, in accordance with the collective bargaining agreement or other agreement with the Union. When the Plan begins to receive vacation benefit contributions on your behalf, the Plan establishes an Individual Vacation Account on your behalf.

Your Individual Account

Contributions made by your employer on your behalf are credited to an Individual Vacation Account that is established in your name. All contributions are made by Employers in accordance with their collective bargaining or other agreements with the Iron Workers Locals 40, 361 and 417. The collective bargaining or other agreements require contributions based on a fixed rate per hour paid.

You or your beneficiary cannot pledge or assign any benefits in your Individual Vacation Account that are due you from the Fund, except as collateral for a loan under the Iron Workers Locals 40, 361 and 417 Annuity Fund.

Eligibility to Receive Vacation Benefits

You can apply for the balance of your Individual Vacation Account at any time. To receive your benefits you must complete a Vacation Fund withdrawal form and file it with the Fund Office.

If you die before you receive the entire amount in your Individual Vacation Account, your beneficiary will receive the entire amount. You must file a form with the Fund Office designating a beneficiary. If you have not designated a beneficiary or if your beneficiary dies before you, the amount left in your account will be paid to the first surviving person or persons, as follows: your Spouse; if you have no spouse or your Spouse has died, payment will go to your children in equal shares; and if there are no children, payment will be made to your parents in equal shares, if your parents have not survived you, to your brothers and sisters in equal shares. If payment cannot be made to any of the indicated categories, the Fund will pay the death benefit to your estate.

HEALTH BENEFITS

Your Health Benefits are divided into two parts: Hospital and Medical Benefits. Your comprehensive medical benefits include physician and other provider healthcare, outpatient laboratory and x-ray, and other medical services and supplies. These benefits are administered by the Fund Office and are described in the section following the hospital benefits. Your hospital benefits include inpatient hospital and outpatient facility charges. These benefits are administered by Empire Blue Cross Blue Shield (Empire). Following is a brief overview of the medical and hospital benefits.

SUMMARY OF MEDICAL AND HOSPITAL BENEFITS

Benefit	In-Network	Out-of-Network
Coinsurance		
Major Medical Benefits	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	You pay 10% of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Copayment (emergency)		
Major Medical Benefits (Professional)	$15 copayment	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits (Facility)	$50 per visit (waived if admitted to hospital within 24 hours)	
Copayment		
Major Medical Benefits (Professional)	$15 copayment	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits (Hospital Inpatient/Facility)	$250 copayment per admission. Up to $625 maximum per family per year. Co-payment is not applied if you are readmitted into the hospital within 90 days of discharge. The copayment is not applied for "routine nursery care", but is applied for "Maternity Care" or "Birthing Center".	
Annual Deductible		
Major Medical Benefits	Not Applicable	$500 individual, $1,000 combined family
Hospital Benefits	Not Applicable	
Annual Out-of-Pocket Coinsurance Maximum		
Major Medical Benefits	Up to $500 maximum out-of-pocket coinsurance per individual, per	$5,000 maximum per individual, per calendar year, after deductible.

Benefit	In-Network	Out-of-Network
	calendar year, not including surgery, anesthesia, MRI, PET scans	
Hospital Benefits	Up to $1,500 maximum out-of-pocket coinsurance per individual, per calendar year	Not applicable

Benefit	In-Network	Out-of-Network
Acupuncture		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount. Maximum 20 visits per year.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible Maximum 20 visits per year.
Hospital Benefits	Not Applicable	
Allergy Testing and Treatment		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Ambulance • The Plan pays as per scheduled allowances for: private professional ambulance service to the hospital in an emergency or from one hospital to another when medically necessary when you become a hospital bed patient for non-maternity care. • Professional ambulance service when used to transport an individual from the place where the individual is injured by an accident or stricken by a disease to the first hospital where treatment is given. • No other charges in connection with travel are included.		
Major Medical Benefits	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Cardiac Rehabilitation		
Major Medical Benefits (Professional Fees)	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits (Facility Fees)	You pay 10% coinsurance of allowed amount after applicable inpatient copayment. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Chiropractic Care		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Diagnostic Procedures Diagnostic X-ray and laboratory services are covered according to the Plan's scheduled allowances for services performed in: • Doctor's office,		

Benefit	In-Network	Out-of-Network
• Your home (up to the cost of the procedure if preformed at a doctor's office or laboratory), • Licensed laboratories, or • Outpatient department of a hospital.		
Major Medical Benefits (Free standing)	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits (Inpatient or Outpatient Facility)	You pay 10% of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Doctor /Physician or other Health Care Provider Visits (Professional Fees) The Plan pays for unlimited visits, beginning with first visit, for general medical care in your home, in the doctor's office or in the hospital, based on the Plan's scheduled allowances and include: • Service of a legally qualified physician, surgeon or dentist who is duly licensed to prescribe and administer all drugs or to perform all surgery and the service of a credited or registered psychologist. • Services of a registered nurse (R.N.) other than a nurse who ordinarily resides in the insured's home or who is a member of the insured's family. • The fees of a licensed practical nurse (L.P.N.) may be a Covered Medical Expense only if the attending physician submits a written statement that a registered nurse was not available. • Specialist Consultation In or Out of the Hospital. When your doctor calls in a specialist for consultation, the Plan will pay the scheduled allowance for one such consultation in each specialty in each specialty field, for each illness. Referral by your doctor is not required for psychiatric consultations. If the consultation is out of the hospital, allowances are also granted for any necessary diagnostic x-rays and laboratory tests that are part of such consultation.		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Durable Medical Equipment		
Major Medical Benefits	You pay 10% of allowed amount. Plan pays 90% of allowed amount.	According to Plan benefits, You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Emergency Room		
Major Medical Benefits (Professional Fees)	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible.
Hospital Benefits (Facility Fees)	$50 per visit copayment (waived if admitted within 24 hours)	
Genetic Testing Medically necessary genetic testing payable under this Plan is ONLY payable for the following. ***NO OTHER GENETIC TESTING IS COVERED UNDER THE PLAN.***		

Benefit	In-Network	Out-of-Network
• State-mandated newborn screening tests for genetic disorders; • Fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary; • Tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; • Genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis; • BRCA 1 or 2 genetic tests for women at higher risk (e.g., women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes and/or a woman who has previously been diagnosed with cancer); • Genetic Counseling is payable when ordered by a physician, performed by a qualified genetic counselor and provided in conjunction with a genetic test that is payable by this Plan.		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Home Health Care Up to 200 visits combined per calendar year (4 hours of care equals one home care visit)		
Major Medical Benefits	Not covered	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits *(Fund only covers Home Health Care providers covered by Blue Cross)*	You pay 10% of allowed amount. Plan pays 90% of allowed amount. (No copayment required.)	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Visiting Nurse Service The Plan pays as per scheduled allowances for visits to your home by a Registered Nurse from an accredited Visiting Nurse Service when requested by the attending Physician.		
Major Medical Benefits	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Inpatient Hospital Services (Facility Fees) Semi-Private Room And Board; Anesthesia and Oxygen; Blood Derivatives; Cardiac Rehabilitation; Chemotherapy and Radiation Therapy; Diagnostic X-Rays and Lab Tests; Drugs and Dressings; General, Special and Critical Nursing Care; Intensive Care; Kidney Dialysis		
Major Medical Benefits	Not Applicable	

Benefit	In-Network	Out-of-Network
Hospital Benefits	$250 copayment per admission, then 10% coinsurance of allowed amount after applicable inpatient copayment. Plan pays 90% of allowed amount.	$250 copayment per admission, then You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Maternity Prenatal Care & Delivery The Plan pays scheduled allowances for maternity care. Payments for maternity care include doctor visits before and after the child is born; Routine Newborn Nursery Care (In Hospital); Obstetrical Care (In Hospital or Birthing Center);		
Major Medical Benefits (Professional Fees)	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits (Facility Fees)	$250 copayment per admission, then 10% coinsurance of allowed amount after applicable inpatient copayment for obstetrical / maternity. Plan pays 90% of allowed amount. (There is no copayment for routine nursery care)	$250 copayment per admission, then You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible (There is no copayment for routine nursery care.)
Mental Health (Inpatient) *Major Medical Benefits (Professional Fees)*	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible.
Hospital Benefits (Facility Fees)	$250 copayment per admission, then 10% coinsurance of allowed amount after applicable inpatient copayment. Plan pays 90% of allowed amount.	$250 copayment per admission, then You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Mental Health (Outpatient) *Major Medical Benefits (Office Visits/Professional Fees)*	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible.
Hospital Benefits (Other Outpatient/Facility Fees)	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Radiation *Major Medical Benefits (Professional)*	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible

Benefit	In-Network	Out-of-Network
Hospital Benefits (Outpatient Facility)	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Substance Abuse Disorder (Inpatient) *Major Medical Benefits (Professional Fees)*	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible.
Hospital Benefits (Other Outpatient/Facility Fees)	$250 copayment per admission, then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	$250 copayment per admission, then You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Substance Abuse Disorder (Outpatient) *Major Medical Benefits(Office Visits/Professional Fees)*	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible.
Hospital Benefits (Other Outpatient/Facility Fees)	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible.
Surgery and Anesthesia (Professional Fees) *Major Medical Benefits*	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	
Physical, Occupational, Speech, and Vision Therapy and Rehabilitation (Inpatient - Up to 30 days of inpatient service per calendar year)		
Major Medical Benefits	Not Applicable	
Hospital Benefits	$250 copayment per admission, then 10% coinsurance of allowed amount after applicable inpatient copayment. Plan pays 90% of allowed amount.	$250 copayment per admission, then You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Physical, Occupational, Speech, and Vision Therapy and Rehabilitation (Outpatient) *Major Medical Benefits (Office Visits/Professional Fees)*	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible

Benefit	In-Network	Out-of-Network
Hospital Benefits (Outpatient Facility)	Not Applicable	
Preventive Care		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	Not Applicable	Not Applicable
Outpatient (Same Day/Ambulatory) Services Anesthesia and Oxygen; Blood Work for Emergency Care or Ambulatory Surgery; Same Day (Outpatient/Ambulatory) Surgery		
Major Medical Benefits (Professional/Surgeon Fees)	You pay 10% of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits (Facility Fees)	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible (No copayment required.)
Skilled Nursing Facility Up to 60 days per calendar year		
Major Medical Benefits	Not Applicable	
Hospital Benefits	$250 copayment per admission, then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount. (No copayment required.)	$250 copayment per admission, then You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible (No copayment required.)
Hospice Care Up to 210 days per lifetime		
Major Medical Benefits	Not Applicable	
Hospital Benefits	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount. (No copayment required.)	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible (No copayment required.)
Well Woman Care (available only in outpatient department of hospital) Pap smears		
Major Medical Benefits	You pay 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	No Charge	

Benefit	In-Network	Out-of-Network
Well Woman Care **Mammogram** (based on age and medical history) ▪ Ages 35 through 39 – 1 baseline ▪ Age 40 and older – 1 per year		
Major Medical Benefits	You pay $15 copayment then 10% coinsurance of allowed amount. Plan pays 90% of allowed amount.	You pay 40% coinsurance of allowed amount after the deductible and any amount above allowed amount. Plan pays 60% allowed amount after deductible
Hospital Benefits	No charge	

HOSPITAL BENEFITS

Your Hospital Plan is administered by Empire. Empire does not underwrite or assume any financial risk with respect to claims liability. However, Empire is the claims administrator and acts as the claims fiduciary for hospital benefits, this includes facility charges for inpatient and outpatient facilities as outlined in the schedule of benefits and detailed in this section. The key to using your Hospital Plan is understanding how benefits are paid. Start by choosing participating or non-participating providers any time you need health care.

Where to Find Participating Providers

Participating services are hospital care services provided by a hospital/facility or health care facility that has an agreement with Empire or another BlueCross and/or BlueShield plan to provide care to Empire's members. Non-participating services are hospital care services provided by a hospital/facility that does not have an agreement with Empire or any BlueCross and/or BlueShield plans.

Empire gives you access to hospitals within the plan's operating area of 28 eastern New York State counties. See "operating area" in the Details and Definitions section for a listing of counties.

Your Benefits (Out-of-Area)

When you live or travel outside of Empire's operating area, Empire's Hospital Plan provides benefits through the following programs:

- *BlueCard® Program.* The BlueCard Program is available whenever you travel in the United States. Simply show your Empire ID card, and you will benefit from discounts that participating providers have agreed to extend to their local BlueCross and/or BlueShield plan. These are "In-Network" benefits.

- *BlueCard® Worldwide*. Need emergency services when traveling outside the United States? The BlueCard Worldwide program provides coverage through an international network of healthcare providers. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Inpatient care is "In-Network". Out-patient care is "out-of-network".

Manage Your Healthcare Online! Register Now! Do It On The Web!

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

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

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

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

Assistance is a Click Away

Use the Click-to-Talk feature to contact us three different ways:

- E-mail: You can e-mail us with a question 24 hours a day, 7 days a week, and a customer service representative will e-mail an answer back to you through your Message Center.
- Collaboration: Empire's representative will call you while you are online and navigate the site along with you. Empire can even take control of your mouse, making it easier to answer your questions.
- Call Back: You can request that a representative contact you with assistance.

Get Personalized Health Information – Including your Health IQ Click on MY HEALTH from your homepage to receive the following features:

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

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

If You Need Emergency Care

Should you need emergency care for accidental injury or sudden and serious illness, your Empire Hospital Plan is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

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

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

Emergency Assistance 911

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

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

For out-of-network Emergency Care, the Plan follows the "Greater of Three" rule which requires the Plan pay for out-of-network Emergency Care at an amount that is the same method the Plan uses to pay for other out-of-network services. This means your out-of-network Emergency Care is the same cost to you as other out-of-network services.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition.

Tips for Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment.
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. Be sure to show your Empire ID card at the emergency room.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard Worldwide program, simply show your Empire ID card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

These emergency services are not covered:

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

Maternity Care

Obstetrical care in the hospital or birthing center, as well as routine newborn nursery care, are all covered.

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

Following are additional covered services and limitations:

- One home care visit covered by Empire if the mother leaves earlier than the 48 hour (or 96 hour) limit. The mother must request the visit from the hospital or a home health care agency within this time frame (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later. This home care visit is in addition to other home care benefits and is not subject to a deductible or coinsurance.

- Parent education, and assistance and training in breast or bottle feeding, if available

- Semi-private room

Notice Regarding the Newborns' and Mothers' Health Protection Act

This Plan complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits group health plans and health insurance issuers from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's

and newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or MagnaCare for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice Regarding the Women's Health and Cancer Rights Act

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 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the patient and 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 of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information on WHCRA benefits, the amount of coverage available to you, and copayment, deductible and maximum amounts, please refer to the *Schedule of Benefits.* You may also contact MagnaCare for additional information.

Tips for Getting Hospital Care

- If your doctor prescribes pre-surgical testing have your tests done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room.
- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Outpatient Hospital Care

Following are additional covered services and limitations when performed in the hospital outpatient (same-day) department:

- Blood and blood derivatives. For emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia, this benefit is available on an outpatient basis only
- Cervical cancer screenings. This includes a pap smear and diagnostic services in connection with evaluating the pap smear.
- Mammogram (based on age and medical history)
  - Ages 35 through 39 – 1 baseline
  - Age 40 and older – 1 per year

- Upon recommendation of a physician, a mammogram at any age for covered members having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer

- Same-day and hospital outpatient surgical facilities

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

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

When you use a participating hospital, you will not need to file a claim in most cases. When you use a non-participating hospital, you may need to file a claim with Empire.

- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare. The Fund pays for the first 3 months of treatment, then care is covered by Medicare. Medicare then pays for thirty (30) months then reverts to the Fund if patient has treatment for underlying illness (transplant, etc.). If not, Medicare continues to provide coverage:
  - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered)
  - In a hospital-based
  - In a free-standing facility

These outpatient services are not covered:

- Routine medical care including minor surgical procedures which do not require use of the surgical facilities, such as any incisions or punctures of the skin or other tissue. It does not include
- Inoculation, vaccination:
- Collection or storage of your own blood, blood products
- Drug Administration or injection

Inpatient Hospital Care

Following are additional covered services for inpatient care:

Semi-private room and board when

- The patient is under the care of a physician, and
- A hospital stay is medically necessary.

Coverage is for unlimited days

- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital (if their services are included in hospital charges)
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery
  - Surgery on the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

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

Inpatient Hospital Care

- Use of cardiographic equipment
- Drugs, dressings and other medically necessary supplies
- Social, psychological and pastoral services
- Inpatient admission exclusively for physical, occupational, speech and vision therapy
- Chemotherapy and radiation

These inpatient services are not covered:

- Private duty nursing
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semi-private room. The additional cost cannot be applied to your coinsurance.

- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated immediately on an inpatient basis could result in serious bodily harm or risk to life
- Services performed in the following:
  - Nursing or convalescent homes
  - Institutions primarily for rest or for the aged
  - Rehabilitation facilities (except for physical therapy and behavioral health)
  - Spas
  - Sanitariums
  - Infirmaries at schools, colleges or camps
- Any part of a hospital stay that is primarily custodial or for a rest cure or convalescent or sanitarium type care or care that is not curative or restorative and is not a form of medical treatment. There are no benefits for care in a hospital, or in a separate division of a hospital, where half or more of the days of care provided by that hospital or that separate division of the hospital are during stays of more than 90 days in length
- Hospitalization or treatment of cosmetic surgery. However, cosmetic surgery shall not include reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or reconstructive surgery of the breast, when a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance. For a covered child, benefits are available for cosmetic or reconstructive surgery for a functional defect which is caused by a congenital disease or anomaly.
- Hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility.

Skilled Nursing and Hospice Care

You receive coverage through Empire's Hospital Plan for inpatient care in a skilled nursing facility or hospice. Benefits are available in a facility that has a participating agreement with Empire or another Blue Cross or Blue Shield Plan or in a facility that is approved by The Joint Commission. You are responsible for the applicable coinsurance. You are covered for inpatient days in a participating skilled nursing facility if you need medical care, nursing care or rehabilitation services when such care is, in E judgment, medically necessary and appropriate and approved by Empire. The number of covered days is listed in your Hospital Benefits certificate of coverage from Empire. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

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

- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other health care professional.
- The following skilled nursing care services are not covered:
- Skilled nursing facility care that primarily:
  - Gives assistance with daily living activities
  - Is for rest or for the aged
  - Treats drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures

Hospice Care

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

Hospice care must be provided by a hospice organization, which has a participation agreement with Empire and/or another Blue Cross or Blue Shield Plan, or is certified under Article 40 of the New York Public Health Law. If the Hospice is located outside of New York state, the hospice must have a similar certification process required by the state in which the hospice organization is located, or approved by The Joint Commission. Following are additional covered services and limitations:

  - Bed patient care either in a designated hospice unit or a regular hospital bed
  - Day care services provided by the hospice organization
  - Home care and outpatient services which are provided by the hospice and which the hospice charges you. Hospice care services, includes:
  - Intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN), or Home Health Aide
  - Physical, occupational, speech and respiratory therapy
  - Social services
  - Nutritional services
  - Laboratory tests, x-rays, chemotherapy and radiation therapy when required for control of symptoms

- Medical supplies
- Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference
- Medical care given by the hospice doctor
- Five visits for bereavement counseling for the member's family either before or after the member's death
- Durable medical equipment
- Transportation between home and hospital or hospice when medically necessary

Tips For Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility ask your doctor or case worker to refer to your Empire Provider Directory.
- When selecting from among multiple facilities, you may want to consider:
  - Is the facility's location convenient to friends, relatives and doctors?
  - What size facility is most suitable? A large facility may have more activities; a smaller one may be more personal.
  - Are visiting hours convenient for friends and relatives?
  - Who directs your care? Does your doctor have privileges at the facility?

For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

Home Health Care

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You will receive medically necessary benefits for home health care if provided and billed by a participating or non-participating home health care agency. A non-participating home health agency must be certified under Article thirty-six of the New York State Public Health Law or have comparable certification in another state.

Following are additional covered services and limitations:

- Up to 200 home health care visits per calendar year for any combination of services listed below when provided by a home health care agency. Four hours of care equal one home care visit. Your physician must certify the need for home health care and approve a written treatment plan.
- Home health care services include:
  - Nursing care

- Intermittent or part-time home nursing care. The care must be provided by or under the direct supervision of a registered nurse

- Intermittent or part-time care provided by home health aids. Four hours of care equals one home care visit.

- Rehabilitation care consisting of physical, speech or occupational therapy provided by the home health agency

- Medical needs

  Medical supplies, drugs and medications prescribed by a physician and laboratory services provided by or on behalf of a home health agency to the extent services would be covered if the covered member was in a hospital or a Skilled Nursing Facility as defined by Medicare.

The following home health care services are not covered:

- Custodial services, including assistance in activities of daily living such as bathing, feeding, changing

- Services that do not require skilled personnel

Physical Therapy

You receive inpatient benefits through Empire's Hospital Plan for physical therapy, physical medicine or rehabilitation.

Tip for Receiving Therapy

- Ask for exercises you can do at home that will help you get better faster.

- Covered services and the number of inpatient days are listed in Your Hospital Benefits At A Glance. Following are additional covered services and limitations:

- Inpatient admissions exclusively for physical therapy, physical medicine or rehabilitation services, or any combination of these if:

  - Prescribed by a physician,

  - Designed to improve or restore bodily functions within a reasonable period of time,

  - Received in a hospital or facility that is participating with Empire or approved by The Joint Commission.

- Inpatient therapy must be short-term.

The following therapy service is not covered:

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

- Outpatient physical, occupational, speech and vision therapy services

Mental Health and Substance Use Disorder Benefits

Your mental health is as important as your physical health. Your mental healthcare benefits cover treatment for mental health and substance use disorder in participating or non-participating facilities. The following services are covered:

- Inpatient care for mental health and substance abuse disorders. Inpatient care for detoxification and rehabilitation is also covered.
- Outpatient facility-based programs for mental health and substance abuse disorders.
- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins.

Outpatient treatment at facilities for substance use disorder that are covered must:

- Have New York State certification or be certified pursuant to Article 31 or 32 of the New York Mental Hygiene Law, or approved by the Joint Commission of Accreditation of Healthcare Organizations.
- be approved by the Joint Commission of Accreditation of Healthcare Organizations if out of state.
- The program must offer services appropriate to the patient's diagnosis.

Exclusions and Limitations Under Your Hospital Plan

In addition to services mentioned under "What's Not Covered" in the prior sections, your Hospital Plan does not cover the following:

Dental Services

Benefits will not be provided for dental care or treatment.

Experimental/Investigational Treatments

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, or when requested by an external appeal agent, Empire will not cover any treatment, procedure, drug, biological product or medical device or any hospitalization in connection with such technology if, in Empire's discretion, it is determined that such technology is experimental or investigational.

"Experimental" or "investigative" means that the technology is:

- Not of proven benefit for the particular diagnosis or treatment of the covered member's particular condition, or
- Not generally recognized by the medical community as reflected in published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.

  Empire will also not cover any technology or any hospitalization in connection with such technology if, in Empire's discretion, such technology is obsolete or ineffective and is not used

generally by the medical community for the particular diagnosis or treatment of the covered person's particular condition.

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

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, (e.g. investigational device exemption or an investigational new drug exclusion), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require any or all of the five criteria be met.

- Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

- Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).

- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

- Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Government Hospital Programs

Services for benefits if the member elects to receive Medicare or any other governmental program, except Medicaid. Government hospital services, except:

- Specific services covered in a special agreement between Empire and a government hospital

- United States Veteran's Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.

Home Care

Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency.

Inappropriate Services

- Services or items or any portion of a stay in a hospital or facility covered under the plan, that in its judgment, are not needed for proper medical care. If services or items or any portion of a stay are provided that cost more than other types of care, which in its judgment, are equally or more beneficial, benefits may be limited to the cost of the less expensive type of care.

- Services usually given without charge, even if charges are billed.

- Services performed by hospital or institutional employees unless their services are included in the hospital charges and professional services of providers

Medically Unnecessary Services

Services, treatment or supplies not "medically necessary" defined in this document and determined by Empire.

Miscellaneous

Surgery and/or treatment for gender change

Prescription Drugs

All prescription drugs and over the counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication, unless specifically indicated.

Services Provided Pursuant to a Prohibited Referral

Services such as laboratory, radiation therapy, x-ray or imaging, and pharmacy services as required by New York State Public Health law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship.

Sterilization/Reproductive Technologies

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

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

War: Services for illness or injury received as a result of war.

Workers' Compensation, No-Fault and Similar Legislation

Expenses covered under Workers' Compensation, the Federal Employers' Liability Act, the Longshoremen's and Harbor Workers' Compensation Act, Jones Act or similar law, and/or mandatory portion of a no-fault automobile insurance policy and similar legislation unless and until the covered person has exhausted all of the benefits available under these laws. This applies even if the covered member does not claim benefits under the laws or policies of after any of the above benefits are paid, the covered member must repay them because he or she recovers that money in a lawsuit or other proceedings.

Limitation as Independent Contractor

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

If You Need To File A Claim

Empire's Hospital Plan makes health care easy by paying providers directly when you use participating providers. Therefore, when you receive care from providers or facilities that participate with Empire, you generally do not have to file a claim. A non-participating provider may arrange to file a claim directly with Empire or may bill you directly. In that case, you will have to file a claim for reimbursement for covered services received from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service.

Send completed forms to:

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

Tips for Filing a Claim

- File claims within 180 days of date of service.
- Contact Member Services at 1-800-342-9816 if you need a claim form.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

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

Empire has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one group health plan. Please note the benefits provided by Empire will be coordinated with any

benefits you are eligible to receive under the other group health plan. Together, the plans will pay up to the amount of covered and allowable expenses, but not more than the amount of actual expenses.

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

Please note these provisions apply to the Empire Hospital Provisions. See the Medical section for details on Coordination of Benefits for those benefits.

Which Plan Pays Benefits First?

Here is how Empire determines which plan has primary responsibility for paying benefits:

- If the other health plan does not have a coordination of benefits provision, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans and the parents are not separated or divorced, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
- For a dependent child covered under both parents' plans, the parents are divorced or separated and there is no court decree establishing financial responsibility for the child's health care expenses:
  - The plan covering the parent with custody is primary.
- If a dependent child is covered under both parents' plans, the parents are separated or divorced and there is no court decree between the parents' which establishes financial responsibility for the child's medical care expenses:
  - The plan of the parent who has custody (the custodial parent) shall be primary
  - If the custodial parent is remarried, and the child is also covered as a dependent under the step-parent's plan, the custodial parent's plan shall pay first, the step-parent's plan second and the non-custodial parent's plan third.
- If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's medical care expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are covered under one plan as an active employee, or as the dependent of an active employee, and is also covered under another plan as a laid-off or retired employee or as the dependent of a laid-off or retired employee, the plan which covers you as an active employee, or as the dependent of an active employee, shall

be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which is primary, this rule will be ignored.

If none of these rules apply, the plan that has covered the patient longest is primary.

If Empire is the Secondary Plan

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

Allowable expense is the necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

The claim determination period is the calendar year over which allowable expenses are compared with total benefits payable in the absence of Coordination of Benefits, to determine whether over insurance exists; and how much each plan will pay or provide.

Tips for Coordinating Benefits

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

Right to Recover Overpayment

If Empire made a payment even though the covered member had coverage under another plan, the covered member agrees to pay Empire any amount by which Empire should have reduced Empire's payment. Also, Empire may recover any overpayment from the other plan or provider receiving payment and the covered member agrees to sign all documents necessary to help Empire recover any overpayment.

Health Care Fraud

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

If You Have Questions About A Benefit Payment

Empire reviews each claim for appropriate services and correct information before it is paid.

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

The notification will give you:

- The specific reason(s) for the denial

- References to the pertinent plan provisions on which the denial is based

- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary

- An explanation of claims review procedures

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

Complaints, Appeals And Grievances

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

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

If your complaint, grievance or appeal concerns behavioral healthcare, call 1-800-635-6626 or write to:

Empire Mental Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

Empire will resolve complaints within the following time frames:

- Standard complaints. Within 30 days of receiving all necessary information.

- Expedited complaints (complaints that require a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim). Within 72 hours of receiving all necessary information.

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

Provider Quality Assurance

Because your healthcare is so important, Empire has a Quality Assurance Program designed to ensure that Empire's network providers meet high standards for care. Through this program, Empire will continually evaluate its network providers.

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

Empire also encourages you to send suggestions to Member Services for improving Empire's policy and procedures. If you have any recommendations on improving Empire's policies and procedures, please send them to the Member Services address on this page.

Your Right to Appoint a Representative

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

Appeals

You as a group member have certain rights and protections and the group may have duties as the Group Administrator. Among them is the right to appeal a claim decision for any reason other than a denial based on medical necessity or experimental or investigational. If Empire denies a claim, wholly or partly, you may appeal its decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal Empire's decision. You or your authorized representative may submit a written request for review. You may ask for a review of pertinent documents and you may also submit a written statement of issues and comments. The claim will be reviewed and Empire will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

Utilization Review

Empire has a Utilization Review process to review medical services provided to you to determine whether the services were medically necessary. Utilization Review is conducted by:

- Trained administrative personnel, under the supervision of a trained health care professional;
- A trained health care professional, and;
- Where the review involves an adverse determination, a clinical peer reviewer. A clinical peer reviewer is a licensed physician or other licensed, certified or appropriately credentialed professional, who is in the same profession and same or similar specialty as a health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review.

Notification

All services are subject to retrospective review to determine if they were medically necessary. If Empire determines retrospectively that the service was not medically necessary, Empire will notify you in writing within 30 days of its receipt of the information necessary to render a decision and you will be liable for any service which Empire determines, in Empire's sole judgment, to be medically unnecessary.

A notice of an adverse determination will be in made writing and will indicate the reason for the determination, including the clinical rationale if any, for the determination; instructions on how to make a standard or external appeal; notice of the availability upon request of the Covered Person or his/her designee, of the clinical review criteria relied

on to make the determination. The notice will also specify what, if any, additional necessary information must be provided to, or obtained by Empire in order to made a decision on appeal.

In the event that Empire renders an adverse determination without attempting to discuss such matter with the member's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective review, such reconsideration shall occur within one business day of receipt of the request and will be conducted by the member's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, Empire shall provide written notice and documentation.

Failure by Empire to make a determination within these time frames shall be considered an adverse determination subject to appeal as described above.

Standard Appeal

If you disagree with the Utilization review decision, you have the right to appeal the decision. The appeal may also be made by your designee or health care provider. You or your authorized representative may file a formal appeal by telephone or in writing.

Final determination. The notice of the appeal determination will include:

- The reasons for the determination; provided, however, that where the adverse determination is upheld or appeal, the notice shall include the clinical rationale for such final adverse determination; and

- Appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

Level 1 Appeals

A Level 1 Appeal is your first request for review of the initial reduction or denial of benefits. You have 180 calendar days from the date on the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review. If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date. Qualified clinical professionals who did not participate in the original decision will review your appeal. Empire will make a decision within the following time frames for 1st Level Appeals:

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

- *Retrospective*. Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal. If Empire's Medical Management Program does not make a decision within 60 calendar days of receiving all necessary information, Empire will approve the service. A Level 1 Appeal submitted beyond the 180-calendar day limit will not be accepted for review. A Level 2 Appeal submitted beyond the 60-business day limit will not be accepted for review.

Expedited Level 1 Appeals

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

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

Expedited Appeals may be filed by telephone and in writing. Please note that appeals of claims decisions made after the service has been provided cannot be expedited.

When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum time frames:

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

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal options. If Empire's Medical Management Program does not make a decision within 2 business days of receiving all necessary information to review your appeal, Empire will approve the service.

Level 2 Appeals and Timeframes

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

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

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

Empire will not provide coverage for any service that is not a covered service under your contract.

Level 1 Grievances

A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity. The types of decisions that may be reviewed through the grievance process

include denials of a request for a referral to an out-of-network provider, benefit denials based on a specific limitation in the subscriber contract (e.g., no pre-certification was obtained), and complaint decisions where the member disagrees with Empire's findings.

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

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

A qualified representative who did not participate in the original decision will review your grievance.

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

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

- Post-service (services have already been rendered). Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

Expedited Level 1 Grievance

When a delay would significantly increase the risk to a patient's health, Empire will respond to your grievance within 48 hours after receiving all necessary information. If all necessary information has not been received within 72 hours of Empire's receipt of the grievance, Empire will make a decision based on the information in its possession at that time. You will be notified of the decision by telephone, and a written decision will be mailed within two business days after the telephone call.

Level 2 Grievances

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

Empire will make a decision within the following time frames for 2nd Level Grievance:

- Pre-service. Empire will complete its review of a pre-service grievance within 15 calendar days of receipt of the grievance.

- Post-service. Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

Expedited Grievances

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

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

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

How to File an Appeal or Grievance

To submit an appeal or grievance, call Member Services at 1-800-553-9603, or write to one of the following addresses with the reason why you believe Empire's decision was wrong. Please submit any data to support your request and include your member I.D. number and if applicable claim number and date of service.

The address for filing an appeal or grievance is:

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

If your grievance or appeal concerns behavioral healthcare, call 1-800-635-6626 or write to:

Empire Mental Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

Definitions That Pertain To Empire Benefits

Refer to these definitions to help you better understand your Empire coverage. Need more help? Additional terms and definitions can be viewed at www.empireblue.com.

Allowed Amount

The maximum Empire will pay for each covered service under this plan when such services are determined by Empire to be medically necessary and appropriate for hospital and/or facility services. The Allowed Amount is based on an agreement between Empire and the hospital and/or facility. If there is no agreement, then the Allowed Amount will be the charges of the hospital or facility, for covered services. In no event will the Allowed Amount exceed the hospital or facility charges for services rendered.

Ambulatory Surgery/ See "same-day surgery."

BlueCard® Program

The BlueCard Program helps reduce your costs when you obtain care outside of the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan (local Blue Plan). Just show your Empire BlueCross BlueShield ID card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.

When you obtain health care through the BlueCard Program, the portion of your claim that you are responsible for (member liability) is, in most instances, based on the lower of the following:

- The billed amount that the participating provider actually charges for covered services, or
- the negotiated price that the local Blue Plan passes on to Empire.

The negotiated price may reflect:

- a simple discount from the provider's usual charges, which is the amount that would be reimbursed by the local Blue Plan;
- an estimated price that has been adjusted to reflect expected settlements, withholds, contingent payment arrangements and any non-claim transactions with the provider; or
- the provider's billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

Plans using the estimated price or average savings methods may adjust their prices in the future to ensure appropriate pricing. However, the amount you pay is considered the final price.

A small number of states have laws that require that your member liability be calculated based on a method that does not reflect all savings realized, or expected to be realized, by the local Blue Plan on your claim, or that requires that a surcharge be added to your member liability. If you receive covered health care services in any of these states, member liability will be calculated using the state's statutory methods that are in effect at the time you receive care.

If you have any questions about the BlueCard Program, contact Member Services.

BlueCard® Worldwide Program

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

- Call 800-810-BLUE (2583), 24 hours a day, seven days a week, for the names of participating hospitals
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as copayments, coinsurance, and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

- If you receive outpatient hospital care from a hospital in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any copayment and amount above the allowed amount

Copayment: The payment, expressed in dollars, that must be made by the Covered Person for certain services.

Coinsurance: The payment of eligible health care expenses for which the covered person has financial responsibility to pay. This is often a fixed percentage of covered expenses to be paid.

Covered Services: The services for which Empire provides benefits under the terms of your contract.

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

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care
- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

For pregnancy and childbirth services, the definition of "hospital" includes any Birthing Centers.

Benefits for physical therapy, physical medicine or rehabilitation must be received from a hospital or facility participating with Empire or is approved by The Joint Commission.

For outpatient kidney dialysis treatment, a facility in New York State qualifies for participating benefits if the facility has an operating certificate issued by the New York State Department of Health, is approved by The Joint Commission, or participates with Empire. In other states, the facility must be certified by the state using criteria similar to New York or approved by The Joint Commission.

Empire's Hospital Plan does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; and infirmaries at schools, colleges or camps.

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

Medically Necessary Treatment: Treatment, service, or supplies provided by a hospital or facility 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 physician or other provider,
- Not primarily custodial, and
- The most appropriate level of service that can be safely provided to the patient.

Non-Participating Hospital/Facility: A hospital or facility that does not have a participation agreement with Empire BlueCross BlueShield or another Blue Cross and/or Blue Shield plan to provide services to persons covered under the Empire Hospital contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full.

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

Outpatient Surgery: See "same-day surgery."

Participating Provider: Participating provider means a hospital or facility which has a participating agreement with Empire to provide services covered under this plan to covered members, or has a participating agreement with another Blue Cross or Blue Shield Plan to provide covered services. This definition applies to all references to participating provider unless the contract specifically states otherwise.

Provider: An entity, hospital or facility, that provides covered benefits to persons eligible for coverage, or any other licensed professional provider.

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

Treatment Maximums: Maximum number of treatments or visits for certain conditions.

COMPREHENSIVE MEDICAL PLAN

The Comprehensive Medical Plan is administered by the Fund Office. It is designed to cover medical expenses that are a result of non-occupational accidental bodily injuries or diseases.

In-Network MagnaCare Medical Benefits

You are always free to see any doctor you choose. However, the Plan has contracted with MagnaCare to provide you with the option of In-Network benefits at a lower cost to you and your family. In-Network providers have agreements with MagnaCare in which they provide health care services and supplies for a favorable negotiated fee applicable only to Plan participants. When you and/or your Dependents use the services of an In-Network provider, you are responsible for paying only the applicable Coinsurance or Copayment for any Medically Necessary services. There is no deductible to meet and your out-of-pocket costs are generally lower.

The Copayment for In-Network office visits, specialist consultations or radiology is $15 per visit. The Coinsurance amount when you use In-Network providers is 10% but no more than $500 per person per calendar year. The Plan will pay 90% of the allowed amount for in-network services and supplies. Once your out-of-pocket expenses total $500 during one calendar year, the Plan pays 100% of the allowed amount after copay, if applicable, for in-network services excluding surgery, MRIs, anesthesia, and PET scans.

For a listing of MagnaCare participating providers and a listing of the medical and surgical services provided by these providers, please visit the Magnacare or Magnacare Firsthealth websites aforementioned in this booklet. If you live in a state other than New York, New Jersey, or Connecticut, Magnacare is not available to you. For members outside of the tri-state area, you will receive a Magnacare Card with a First Health designation. Outside of New York, New Jersey, or Connecticut you may use the First Health network of providers in your home state only.

Out-Of-Network Medical Benefits

You may continue to see any doctor you choose, however quite some time ago the Plan contracted with MagnaCare to provide you with the option of in-network benefits at a lower cost to you.

If you receive services from doctors that are NOT in the MagnaCare medical networks, you are responsible for the out of network service as follows:

You must meet deductibles of $500 per individual or $1,000 per family, before the Plan begins to pay for your Covered Medical Expenses each calendar year.

If you use an out of network provider, the Plan will pay 60% of the Plan's **allowed amount** charges of your Covered Medical Expenses after you have met your deductible. You will be responsible for paying 40% of the charges and any amount above the Plan allowed amount.

Once you have incurred charges of up to $5,000 and paid 40% coinsurance of that $5,000 in addition to your deductible, the Plan will pay the rest of your covered expenses at 100% of the Plan's Scheduled Allowed charges for the remainder of the calendar year.

If you choose doctors that are IN the MagnaCare network, you and your family DO NOT have to meet a deductible; however, you are responsible for the applicable co-pays and co-insurance.

Here is an example of how the Out-Of-Network Comprehensive Medical Plan works for an individual participant:

($500 deductible and 60% co-insurance)

Charges incurred during period February 1 to April 1.

Covered Medical Expenses:

Medical.. $3,000
Registered nurse... +$1,000
Total $4,000
Less deductible that the participant pays .... -$500
Equals a difference of $3,500
Plan pays 60% of $3,500 which equals.. $2,100
Participant pays 40% of $3,500 in out of pocket costs, which equals $1,400

Later in the year, the participant incurs a bill of $3,000 for additional medical expenses. The participant would have been responsible for 40% of this new $3,000 bill ($1,200), however the participant's out-of-pocket maximum for medical expenses is $2,000. Therefore, because he has already paid $1,400 out of pocket this year, he only needs to pay an additional $600 (for a total of $2,000 out of pocket expenses) and the Plan will cover the balance at 100% of the allowable amount. The Plan will then pay 100% of the allowable amount of his covered expenses for the rest of the year.

Covered Medical Expenses

Covered Medical Expenses included under the Plan are the charges that you are required to pay for the following services and supplies received, while you are covered, for the treatment of non-occupational accidental bodily injuries and diseases.

The Comprehensive Medical Plan includes the following services rendered to you or your eligible Dependents by a legally qualified physician of your choice after you have met the applicable deductibles and copayments.

You are not required to pre-certify benefits under the Plan. However, if your physician recommends surgery or another course of treatment you wish to have reviewed, you may contact the Fund to provide you with an estimate of benefits under the Plan. This will give you a change to know before you have the surgery or treatment whether or not the recommended surgery or treatment meets the Plans definition of medical necessity or is otherwise excluded or limited Please be advised that although the Plan offers this service, such inquiries do not constitute a claim under the terms of the Plan.

Member's Assistance Program

The purpose of the Member's Assistance Program (MAP) is to provide prompt attention from an individual trained in the area in which you need assistance. It is designed to provide assistance to participants and their Dependents who have problems with alcoholism or drug dependency. Participants and their families should rest assured that this assistance is provided with complete confidentiality. The Fund recognizes that these illnesses may affect a person's ability to function both on and off the job, but that timely and proper treatment by trained personnel can prevent more serious problems from developing. Participants or their Dependents who suffer from these problems, or who recognize a family member who does, can seek assistance by contacting the Coordinator of the MAP Mr. Jim Dufficy at (212) 679-1513. The Coordinator will help to refer you to an appropriate provider or institution where care can be provided.

PRESCRIPTION DRUG BENEFITS

Covered drugs are those that, by either State or Federal laws, may be purchased only by prescription, except oral contraceptives, which are not covered. Also covered is insulin and prescriptions that must be compounded by the pharmacist. The Plan does not cover drugs that can be legally dispensed without a prescription, such as aspirin, even though the doctor may have prescribed them. No coverage is provided for "over-the counter" drugs, vitamins, diet supplements, etc., even if prescribed by a physician. In addition, drugs such as Viagra, Propecia and Retin-A are not covered. For a complete list of excluded drugs and a list of provider locations, please contact Optum Rx. Requests for coverage of any new drug not covered will be reviewed and determined by the Trustees on a case by case basis. Drugs administered while you are in the hospital on an inpatient basis, are also not covered. There is no coverage for drugs administered in connection with a Worker's Compensation claim.

While you are free to use any pharmacy, the Fund has contracted with a prescription drug company listed in the Quick Reference Chart of this document to provide prescription drugs at discounted prices. Simply present your prescription drug card to the pharmacist and pay the required co-payment as listed below:

Prescription	Retail (Pharmacy)	Mail-Order
Generic Medications	$10	$20
Formulary Brand Name Medications	$25	$50
Non-formulary Brand Name Medications	$50	$100

The discounted list of drugs are typically referred to as a "formulary" list. You may request a copy of the formulary from Optum Rx. It lists generic medications, formulary brand name medications and non-formulary brand name medications. Please have your physician review the formulary list on your next visit. If your doctor prescribes a drug that is not on this list, you will be charged a copayment of $50 (at the pharmacy) or $100 (through mail order) per non-formulary brand name medication as shown in the chart.

Generic medications must, by law, contain the same active ingredients, and be identical in strength and dosage, as their brand-name equivalents. However, they usually cost less than brand-name drugs. Always ask your doctor if there is a generic version of your medication and request that the doctor prescribe the generic version whenever possible. This can save both you and the Fund money. Be sure to ask your pharmacist if your brand name drug has a generic equivalent. If you choose the generic equivalent, the Fund will pay 100% for the generic equivalent after you have paid the co-payment of $10 at the pharmacy or $20 at mail order.

If you or your physician chooses the brand name drug instead of the generic equivalent, the Fund will only pay up to the price of that particular drug's generic equivalent less the co-payment. If the drug is on the formulary list you will be responsible for the $25 co-payment plus the difference between the brand and generic at the pharmacy. If the drug is not on the formulary list then you will be responsible for the $50 co-payment plus the difference between the brand and the generic at the pharmacy. If the brand name drug does not have a generic equivalent, then you will pay only the applicable co-payment $25 or $50. You will not have to pay the difference between the cost of the brand name drug and the generic drug when there is no generic version of that drug available.

If you receive the same maintenance prescription drug at the pharmacy twice, all other refills for the same drug must be provided through the mail-order program.

Through the mail-order program, members generally receive a 90-day supply of drugs, while at retail it is only a 30-day supply. The reasons for offering this mail-order service program are two-fold: (a) to offer you convenience and (b) to promote medication compliance by making maintenance medications more affordable for you. Currently, a prescription for a maintenance medication filled at the retail pharmacy carries one copayment per 30-day supply. By utilizing the mail-order service, you will be able to receive up to a 90-day supply of a maintenance medication for one copayment. With the price differential in copayments, this means that you receive a 90-day supply for the same price you would pay for a 60-day supply at a retail pharmacy. You are required to fill a 90 day prescription for maintenance drugs.

A maintenance medication is defined as:

- A drug that is usually administered continuously, rather than intermittently, typically for the remainder of one's life. This means the patient takes the medication on a scheduled basis year round and not as needed or seasonally.

- A drug in which the most common use is to treat a chronic disease state where therapy is not considered curative. For example, diabetes or high blood pressure.

- A drug that has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic responses over a course of prolonged therapy.

See the Exclusions section (beginning on the next page) for a list of drugs that are excluded/not covered under the Plan.

EXCLUSIONS: EXPENSES NOT COVERED BY THE COMPREHENSIVE MEDICAL PLAN

The following is a list of medical services and supplies or expenses not covered by **the Comprehensive Medical Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

A. General Exclusions

1. **Air Ambulance:** Expenses for emergency transportation through air ambulance

2. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

3. **Costs of Reports, Bills, etc**.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.

4. **Educational Services:** Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, etc., even if they are required because of an injury, illness or disability of a covered individual.

5. **Expenses Exceeding Plan's Scheduled Allowance**: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Scheduled Allowance as defined in the Definitions chapter of this document.

6. **Expenses for Which a Third Party Is Responsible**: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party.

7. **Expenses Incurred Before or After Coverage**: Expenses for services rendered or supplies provided:

    - Before the patient became covered under the Medical Plan; or

    - After the date the patient's coverage ends, except under those conditions described in the chapter of this document describing COBRA Coverage.

8. **Experimental and/or Investigational Services**: Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions section of this document.

9. **Illegal Act**: Expenses incurred by any covered individual for injuries or illness resulting from or sustained as a result of commission or attempted commission of an illegal act, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor.

10. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual.

11. **Non-Emergency Travel and Related Expenses**: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Physician or other Health Care Provider, covered person or family member of a covered person, unless those expenses have been approved by the Plan Administrator or its designee.

12. **Operation of a Vehicle While Intoxicated**: Expenses incurred by any covered individual for injuries caused in a motor vehicle accident if the covered individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the injuries arise as a result of a physical or mental health condition or as a result of domestic violence. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the motor vehicle accident.

13. **Private Room in a Hospital or Specialized Health Care Facility**: The use of a private room in a Hospital or other Specialized Health Care Facility, unless its use is certified as Medically Necessary by the Plan Administrator or its designee.

14. **Services Covered by Workers' Compensation**: Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.

15. **Services for Patient Convenience**: Expenses for patient convenience, including, but not limited to, care of family members while the covered individual is confined to a Hospital or other Specialized Health Care Facility or to bed at home, guest meals, television, VCR, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

16. **Services Not Medically Necessary**: Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions section of this document.

17. **Services Not Prescribed by a Physician**: Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Mental Health Practitioner, Midwife or Nurse Midwife, Chiropractor, Acupuncturist or Podiatrist.

18. **Services Provided by Government:** Expenses for services when benefits for them are provided to the covered person:

    - Under any plan or program established under the laws or regulations of any government, including the federal state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or

    - Under any plan or program in which any government participates other than as an employer;

    - Unless the governmental program provides otherwise.

19. **Services Provided by Relatives**: Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.

20. **Services Provided Without Cost to Recipient**: Expenses for services rendered or supplies provided for which;

- A covered person is not required to pay or which are obtained without cost; or
- There would be no charge if the person receiving the treatment were not covered under this Plan.

21. **War or Similar Event**: Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, (war-like act, riot, insurrection, rebellion, or invasion), except as required by law.

B. Alternative Health Care Services Exclusions

1. **Chelation Therapy:** Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

2. **Faith or Spiritual Healing**: Expenses for prayer, religious healing, or spiritual healing unless the services are provided by a Christian Science Practitioner.

3. **Naturopathic and/or Homeopathic Services**: Expenses for naturopathic and/or homeopathic services or supplies.

C. Behavioral Healthcare Exclusions

1. **Expenses for residential care services for Mental Health Care or Substance Use Disorders which are deemed to be Custodial or not Medically Necessary as defined by this Plan**.

2. **Expenses for hypnosis, hypnotherapy** (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness) **and/or biofeedback** (a technique to teach a person to use signals from their body to reduce tension/anxiety).

3. **Expenses for Mental Health Care services or supplies related to:**

- Screening, diagnosis, and/or treatment of autism spectrum disorder, including but not limited to: screening and diagnostic services, assistive communication devices, behavioral health treatment including applied behavioral analysis (ABA), all therapy including physical, occupational, and speech therapy, prescription drugs, inpatient facility charges, outpatient facility charges, or any services or treatment that are provided pursuant to an individualized (or family) education plan under the New York Education Law or other similar state law. For purposes of this benefit, "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.
- Court-ordered services unless the services are both Medically Necessary and a covered benefit of the Plan.
- Services or treatment that are provided pursuant to an individualized, family education plan or other similar such plan under the New York Education Law or other similar state law.

However, the Plan will provide supplemental coverage for any Medically Necessary expenses that would otherwise be covered under the Plan after payment is made pursuant to such a plan.

- Parental custody services, adoption services or family planning counseling including counseling for pregnancy and fertility services;
- Reading and learning disorders, dyslexia, educational delays, or vocational disabilities;
- Group counseling without patient present
- Marriage/couples counseling;
- Medical, surgical or prescription drug treatment related to transgender/transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures or reversal of any such procedures.

D. Blood Donation, Collection or Administration Exclusion

1. Expenses for donation, collection, or administration of autologous or direct blood donations and storage.
2. Platelet Rich Plasma injections/PRP or similar biological agents

E. Corrective Appliances and Durable Medical Equipment Exclusions

1. Expenses for replacement of lost, missing, or stolen Corrective Appliances, including Orthotic Devices and/or Prosthetic Appliances, or Durable Medical Equipment.
2. Expenses for Durable Medical Equipment to the extent it exceeds the cost of standard models of such Appliances or Equipment.
3. Diabetic Continuous glucose monitors (CGMs) approved by the FDA for use as adjunctive devices to complement-not replace- information obtained from blood glucose monitors are not covered. Continuous glucose monitors approved by the FDA as therapeutic devices that are intended as a replacement of blood glucose monitors for diabetes treatment are covered. Replacements will only be covered at the end of the warranty period. The Plan will only pay for the equivalent of the least expensive model available.

F. Cosmetic Services Exclusions

1. Surgery or medical treatment to improve or preserve physical appearance, but not physical function, as distinguished from Medically Necessary Surgery or treatment to correct defects resulting from trauma, infection or other diseases, or the consequences of treatment of trauma, infection or other diseases. or to correct a congenital disease or anomaly of a covered Child that causes a functional defect. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or Surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

2. However, the Medical Plan does cover Medically Necessary Reconstructive Surgery or treatment if it is required to correct damage caused by traumatic injury that occurs when coverage for the patient is in effect, and involves:

- Reconstructive Surgery when it follows Surgery covered by the Plan that results from trauma, infection or other disease; and

- Reconstructive Surgery to correct the effects a congenital disease or a gross developmental anomaly of a covered Child that causes a functional defect.

- Breast reconstruction in connection with a mastectomy.

G. Custodial Care Exclusions

1. Expenses for Custodial Care as defined in the Definitions chapter of this document, whether provided in the home or in any facility whatsoever that is determined by the Plan Administrator or its designee to be primarily domiciliary or custodial, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, except when Custodial Care is provided as part of a covered Hospice program.

2. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are not considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are not covered, even if they are Medically Necessary.

H. Dental Services Exclusions

1. Expenses for Dental Prosthetics or Dental services or supplies of any kind, even if they are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat:

   - Teeth;

   - The gums and tissues around the teeth;

   - The parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges);

   - The jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint) ;

   - Bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or

   - Teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

2. Expenses for the treatment of Temporomandibular joint (TMJ) Syndrome.

3. Expenses for Orthognathic and other craniomandibular or maxillary disorders, including but not limited to Orthodontia and treatment of Prognathism and Retrognathism.

4. Expenses for Dental services **may be covered** under the Medical Plan if they are incurred for the repair or replacement of Sound and Natural Teeth or restoration of the jaw if damaged by an external object in an accident if the injury happens while a person is covered. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing.

5. Expenses covered under the Dental Plan, and all expenses excluded under the Dental Plan unless coverage is specifically provided under the Medical Plan.

6. Dental splints

I. Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that:

    - Have not been approved by the U.S. Food and Drug Administration (FDA); or
    - Are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed; or
    - Are Experimental and/or Investigational as defined in the Definitions chapter of this document.

2. Non-prescription (or non-legend or over-the-counter) drugs or medicines.

3. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during Hospitalization, and except for pre-natal vitamins or minerals requiring a prescription.

4. Naturopathic or homeopathic services and substances.

5. Drugs, medicines or devices for:

    - Contraception;
    - Drugs/treatment for erectile dysfunction;
    - Hair growth;
    - Fertility and infertility; and/or
    - Weight control.

6. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.

7. Any prescription drug or medicine for which there is a generic equivalent available in non-prescription form.

8. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Center, or other Health Care Facility.

9. Vaccinations, immunizations, inoculations or preventative injections, except

   - Those provided by the Plan for children and/or adults; and

   - Those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).

10. Any prescription drug or medicine not provided by the Plan's prescription drug program.

11. Serum allergy antigens if prepared for anything other than single visit use.

J. Family Planning (Fertility and Reproductive Care) Services Exclusions

1. Expenses for medical or surgical treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

2. Expenses related to prevention of pregnancy, including, but not limited to, condoms, drugs or medicines such as Depo-Provera, contraceptive devices such as an IUD or diaphragm, implantable birth control devices such as Norplant, except birth control pills.

3. Expenses for routine genetic services, tests and/or procedures performed only for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women, except amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein analysis in pregnant women, and tests for sperm function and quality in men.

4. Expenses for pre-planned home delivery.

K. Foot Care Exclusion

Expenses for foot care, including but not limited to trimming of toenails, removal of callouses, and preventative care, unless the Plan Administrator or its designee determines such care to be Medically Necessary.

L. Genetic Testing

Expenses for genetic tests are not covered by the Plan including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. The only genetic tests that are covered by the Plan are listed as payable in the Schedule of Benefits. Genetic services that are not covered include but are not limited to:

- Expenses for genetic testing for the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants except as specifically covered by this Plan and listed in the Schedule of Benefits;

- Pre-parental genetic testing (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);

- Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;

- Home genetic testing kits/services; and
- Genetic testing determined by the Plan Administrator or its designee to be not medically necessary or is determined to be experimental or investigational.

M. **Gene Therapy**

Expenses related to any course of treatment involving (1) the replacement of a gene that causes an identified medical problem with a healthy gene that does not; (2) introducing genes to fight disease; or (3) inactivating genes that cause medical problems or function improperly.

N. Hair Replacement Procedures, Medications and Devices (Wigs)

Expenses for hair transplantation and other procedures to replace lost hair for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces, except that the Plan will provide benefits for a single wig or toupee if it is required to replace hair lost as a result of chemotherapy.

O. Hearing Care Exclusion

Expenses for the purchase, servicing, fitting and/or repair of hearing aid devices, including, but not limited to hearing aids and cochlear implants, except as covered by the Plan. See the section on Hearing Aid Benefits.

P. Home Health Care Exclusions

1. Expenses for any Home Health Care services; except as provided under the Plan's Home Health Care Coverage.
2. Expenses under a Home Health Care program for services that are provided:
    - By someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or
    - When the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, Custodial Care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage.

Q. Nursing Care Exclusion

Expenses for services of private duty Nurses except where the Plan Administrator or its designee determines that the private duty nursing care is Medically Necessary as defined in the Definitions chapter of this document.

R. Rehabilitation Therapies (Inpatient or Outpatient) Exclusions

1. Expenses for educational, job training and/or vocational rehabilitation.

2. Expenses for massage therapy (except as medically necessary), rolfing and related services.

3. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is /otherwise incapable of participating in a purposeful manner with the therapy services, including, but not limited to coma stimulation programs and services.

4. Expenses for Maintenance Rehabilitation as defined in the Definitions chapter of this document.

5. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin.

S. Transplantation (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplantation, post-operative services and drugs or medicines, and all complications thereof.

2. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.

3. Expenses for insertion and maintenance of an artificial heart or other organ or related device, except heart valves and kidney dialysis, and all complications thereof.

4. Expenses incurred by the person who donates the organ or tissue, unless the person who receives the transplant is the person covered by this Plan.

T. Erectile Dysfunction

U. Weight Management and Physical Fitness Exclusions

1. Expenses for medical or surgical treatment of obesity (bariatric surgery), including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, skin reduction procedures/treatment and any complications thereof, even if those procedures are performed to treat a comorbid or underlying health condition, except bariatric surgery as provided by the Plan regarding morbid obesity (a weight of at least 100 pounds more than normal body weight for the patient’s age, gender, height and body frame and/or a BMI of 40 or higher based on Body Mass Index BMI weight tables generally used by Physicians to determine normal body weight).

   Bariatric surgery is covered once in a person’s lifetime and includes follow up care for up to six months following surgery including one lap band adjustment during this six-month period. Expenses for post weight loss services or complications that result from the covered bariatric surgery are not covered by the Plan.

2. Expenses for medical or Surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe under weight means a weight more than 25 percent under normal body weight for the patient's age,

sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.

3. Expenses for memberships in or visits to health clubs, exercise programs, gymnasium, and/or any other facility for physical fitness programs.

4. Expenses for behavior therapy related to weight loss.

5. Expenses for the adjustment of a lap band after a weight loss procedure.

6. Expenses for post weight loss surgery or complications that arise out of weight loss surgery.

DENTAL BENEFITS

Dental coverage begins after you have maintained medical and hospital coverage for 24 consecutive months, no matter how long the need for dental care has existed. Coverage is administered by the Fund Office. The name of the dental networks are Metrodent Premier through Self-Insured Dental Services (SIDS) and Comprehensive Professional Services (CPS).

Free Choice of Dentist

You may choose any dentist and receive benefits in accordance with the schedule of allowances that you can request by contacting the Fund Office. The Dental Plan provides benefits for both In-Network and Out-of-Network care. Each time you need dental care, you have the choice of using an:

- In-Network Metrodent dentist or CPS dentist or
- Out-of-Network dentist.

While the choice of provider is always yours, when you use an in-network Metrodent or CPS dentist, you will have no out-of-pocket costs for covered and approved services (excluding 1. implants and care or devices related to implants; 2. Some orthodontic treatments) beyond your copayment since these dentists accept the Plan's allowances as payment in full.

When You Visit an In-Network Dentist

As an eligible participant, you can choose from In-Network dentists. When you use an In-Network dentist, there are no out of network costs for any service covered by the plan and no claim forms to file.

To receive a list of participating dentists, call the Fund Office or contact ASONET at www.asonet.com, select plan IRONWORKERS L40-L361-L417.

Copayments

When you use an In-Network dentist, you will not be charged for any services except implants, care or devices related to implants or any orthodontic services other than conventional braces. There are no copayments for diagnostic or preventive services when you use an In-Network dentist.

*Please note that major dental care is always subject to the Dental Consultants, review and approval for payment.

When you visit a non-network dentist, obtain an original itemized bill from your dentist and submit the bill to the Fund Office or the provider may submit the bill to the Fund Office directly.

Out of Pocket Dental Expenses

When you use an out-of-network dentist, you will be responsible up to that provider’s billed amount less the amount the Fund pays in accordance to the Plan’s payment schedule.

What the Plan Pays

For a listing of the Plan’s payment schedule for both In-Network and Out-of-Network service, please contact the Fund Office.

Partial List of Dental Exclusions and Limitations

The Plan does not provide benefits for the following services:

1. Any service unless rendered by a duly licensed dentist;

2. Any procedure or the supplying or fitting of any appliance, unless required in accordance with accepted standards of dental practice;

3. Replacing any lost appliance;

4. Any service for which the patient does not incur a dentist's charge;

5. Any cosmetic services;

6. Injuries, diseases or conditions, the treatment of which is available without cost to the person treated under laws enacted by the legislature of any State or the Congress of the United States (such as Worker's Compensation, Veterans Compensation, etc.);

7. Any service received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trustee or similar person or group;

8. Any prosthetic appliance, fixed or removable, made as an adjunct to periodontal care, unless it replaces a missing tooth;

9. Dental splints;

10. The replacement of fixed bridgework by a denture or dentures unless a period of three years has elapsed from the installation of the original appliance;

11. The replacement of any full or partial permanent denture by another permanent denture unless a period of three years has elapsed from the installation of the original appliance;

12. Expenses for services provided by any dental practitioner who is the parent, spouse, sibling (by birth or marriage), or child of the patient or covered Employee;

13. TMJ services or appliances.

OPTICAL BENEFITS

You are eligible for optical benefits after you have maintained medical and hospital coverage for 24 consecutive months.

Covered Optical Benefits

The Plan pays for one optical exam, up to $25 per year; and one (1) pair of glasses or contacts each year, up to a maximum of $275 per year per covered individual for a total of $300.

You are free to use any provider for this benefit, but the Plan has contracted with Vision Screening, Davis Vision, General Vision Services and Comprehensive Professional Systems, Inc. (CPS). If you visit a provider in either of these networks, your eye exam and a wide selection of glasses may be fully covered by the $275 allowance. Iron Workers are eligible for one pair of prescription safety glasses per year. You can obtain a list of provider locations from the Fund Office.

Optical Benefit Exclusions

The Plan will not pay for:

Any optical expenses not included in the Schedule of Benefits.

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HEARING AID BENEFITS

Covered Hearing Benefits

The Plan pays up to a maximum of $1,800 per ear towards the cost of hearing aids. This benefit is provided not more than once in any three consecutive year period for each eligible person.

Covered hearing aid expenses are normally the charges that an individual is required to pay for hearing aid appliances, hearing analysis, tests or evaluation performed by a physician or an otologist. Covered expenses may also include charges for the cost and installation of a hearing aid that was provided subsequent to the date of a written recommendation by a physician or an otologist.

The Fund has contracted with Hear USA, a discount company that provides discounts on hearing aid prices. While you are free to visit any provider you choose, if you choose a provider who participates in the Hear USA discount program, your hearing tests and most hearing aids may be covered in full. In addition, you can receive discounts on additional hearing aid products. You can obtain a list of provider locations from the Fund Office. You will be required to pay Hear USA directly and submit your itemized claim to the Fund Office for partial or full reimbursement.

Hearing Benefit Exclusions

Exclusions for hearing benefits under this Plan are:

1. Expenses not recommended or approved by a physician or otologist.
2. Expenses for which benefits are payable under any Worker's Compensation Law.
3. Benefits payable under Medicare or any other governmental plan.
4. Non-durable equipment, such as batteries.
5. Special procedures or training such as lip-reading courses, schooling or institutional expenses.
6. Medical or surgical treatment of the ear or ears.
7. Charges for services or supplies, which are covered in whole or in part under any other portion of the Health Plan.

PENSIONER BENEFITS

Retiree Benefits Before age 65

If you retire under the Rules and Regulations of the Iron Workers Locals 40, 361 & 417 Pension Fund as an Regular, Early Retirement or Age 57 Plus 30-Year Service Pensioner you will be entitled to the same benefits as an Active Employee **until you reach age 65 if you have 15 Pension Credits or more**. In addition, your eligible Spouse and Child(ren) will also be entitled to the same benefits outlined in this booklet that are provided to the eligible Spouse and Child(ren) of active employees.

If you retire under the Rules and Regulations of the Iron Workers Locals 40, 361 & 417 Pension Fund as a Disability Pensioner, you will be entitled to the benefits under this Plan, as outlined in this section, for a period of two years from the effective date of your Disability Pension. Beyond such two-year period, benefits will continue, only until the time that you become eligible for Medicare. At that time this Plan will only provide benefits that supplement Medicare. In addition, your eligible Dependents will be entitled to the benefits as outlined in this booklet.

If you retire with a Regular Pension and have 25 years of service or if you retire with an Age 57 Plus 30 Year Service Pension, your spouse will be entitled to lifetime coverage.

After Age 65 - Supplementary Medicare Benefits

You are eligible for supplemental benefits once you become eligible for Medicare benefits and Medicare Part D. Medicare benefits are broken into two parts, Part A which covers hospital benefits and Part B, which covers provider or professional services. While your coverage under the Health Plan will continue when you become eligible for Medicare, Medicare will become the primary payer for your medical expenses and this Plan will pay benefits after Medicare pays its portion of the bill. Benefits that are paid for by this Plan for Medicare-eligible individuals are reduced by the amounts payable under Medicare Parts A (Hospital), B (Professional services) and D (pharmaceutical drugs). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B. Therefore, if you are Medicare-eligible you should enroll in Medicare Part A and B, WHEN YOU ARE FIRST OFFERED THAT OPPORTUNITY, in order to receive the maximum amount of benefits.

Like the active benefits, Pensioner benefits are broken into two parts, Hospital Benefits (insured by Empire BlueCross) and Medical benefits (administered by the Fund Office). Hospital benefits are covered under Part A of Medicare. Supplemental benefits for Part A are covered under an insured contract with Empire BlueCross Senior Care. Supplemental benefits for Part B are administered by the Fund Office.

Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider. If the medical expense is more than the amount covered by both Medicare and the Health Plan, it will be the member's responsibility to pay the difference. No expenses that are not covered by Medicare are payable by the Plan. You must meet the same Plan requirements (e.g., coinsurance, maximum allowances, etc.) as non-Medicare eligible employees. You must also meet the Medicare Part B deductible. You or your health care provider should file a claim first with Medicare, not Empire or the Fund Office. After Medicare processes your claim, forward the Medicare EOB to Empire or the Fund Office for additional processing.

Please note, as with all benefits under this Plan, the Trustees have the right to change the eligibility rules or amend, modify or discontinue all or part of this benefit whenever, in their sole judgment, conditions so warrant.

See the "How Benefits are coordinated/coordination of Benefits under Medicare and other Governmental Programs" for details on how much this Plan pays when Secondary to Medicare.

For Retirees who are eligible for Medicare Part D

The Fund has contracted with a Medicare Part D Prescription Drug Plan provider. This contract affords you choices of Iron Workers Health Fund Medicare Part D options and provides easy enrollment as well as convenient payment of your premium should there be one.

Who is eligible to enroll

Individuals Age 65 and older and / or Medicare Eligible: Eligible retirees and/or their eligible covered dependents enrolled in Medicare Part A & B are eligible for the Fund's Medicare Part D Prescription Drug Plan.

If a participant does not wish to enroll in any of the Fund's Contracted Medicare Part D Plans

You are not obligated to enroll in any of the Fund's Medicare Part D Plans. You have the option of remaining in the plan which you are presently enrolled or, if you so choose, enrolling in another Medicare Part D Plan. The Health Fund will continue to provide up to $100 towards your monthly premium. As in the past, you will need to submit your monthly invoice to the Fund Office and your reimbursements will be sent to you on a quarterly basis.

Fund's Medicare Part D Enrollment

Beginning October 15 or every calendar year, you can call the Fund Office for enrollment in the Fund's Medicare Part D Plan. Once you have enrolled in one of the Fund's Medicare Part D Plans, you will receive enrollment confirmation by mail, together with plan information, a listing of local retail pharmacies (based on your zip code), and a certificate which shows Evidence of Coverage, including your new Medicare Part D prescription drug card. Remember the enrolment period is October 15 through December 7. You must call the Fund Office before the December 7 deadline in order to enroll.

Remember: If you are presently enrolled in another Medicare Part D plan, enrollment in the Fund's Medicare Part D Plan will <u>automatically</u> cancel that enrollment.

If you enroll in one of the Fund's Medicare Part D Plans and you currently have your monthly Medicare Part D premiums deducted from your monthly Social Security check, it is strongly suggested that you contact the Social Security Administration by <u>telephone and certified letter return receipt</u>, explaining that as of January 1 they should not deduct the monthly Medicare Part D premiums from your monthly Social Security check.

If you have any further questions please contact the Fund Office.

Prescription Drug Benefit for Medicare Eligible Retirees and Spouses

Retirees and their spouses who are Medicare-eligible, who voluntarily enroll in a Medicare Part D Prescription Drug Benefit or the Fund's Medicare Part D Plan for out-patient drugs, are eligible to receive reimbursement of the Part D premiums up to $125 per individual and $250 per family unit per month. You must submit proof that you are enrolled in a Medicare Part D plan along with your premium amount.

Any Medicare-eligible retiree or spouse should consider enrolling in a Medicare prescription drug plan or the Fund's Medicare Part D Plan when they lose the Plan's prescription drug coverage. The next Medicare Part D open enrollment period begins annually on October 15 and lasts until December 7. The Fund will send you more information on this as the end of each calendar year approaches.

You should note that if you do not enroll in a Medicare prescription drug plan when you lose creditable coverage (that is, coverage of equal or greater value than the standard prescription drug coverage under Medicare Part D),

you may pay more later. You will pay a late enrollment penalty in the form of a higher monthly premium for the Medicare prescription drug coverage. If you are eligible for Medicare Part D and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next October to enroll.

All Medicare eligible participants and dependents are encouraged to review the Fund's Medicare Part D Plan and Medicare Part D Plan options that are available in your geographic area and choose the plan that covers most, if not all, of your currently prescribed medications on their "formulary" or "preferred" drug list. For information on the Fund's Medicare Part D Plan, contact the Fund Office.

As with all benefits under this Plan, the Trustees have the right to change the eligibility rules or amend, modify or discontinue all or part of your benefits whenever, in their sole judgment and discretion, conditions so warrant.

Benefits if You Continue to Work and are Medicare-Eligible

If you continue to work after age 65 (when you become eligible for Medicare), you, your Spouse and your eligible Child(ren) are entitled to the same hospital, medical, dental, prescription drug, and optical coverage as if you were under age 65; and you continue to be eligible for life insurance coverage.

If you are retired, this section does not apply to you. For retirement benefits, refer to the separate section of this booklet on retiree benefits. Even though your primary coverage through the Fund continues, you may still apply for Medicare. When you apply for Social Security benefits, you automatically become eligible for Medicare Part A hospital coverage. Part A coverage is free. Medicare Part B coverage, for which you pay premiums, is not usually necessary while you are an active employee. Your benefits without Part B are as complete as those of employees under 65.

Medicare Advantage (formerly known as Medicare Part C) includes a choice of managed care plans, including HMO coverage, as well as medical savings accounts combined with high-deductible medical plans and other coverage options. For Medicare Advantage coverage, you pay the Part B premium amount plus, in some instances, an additional premium amount, depending on the plan chosen.

If you choose not to enroll in Medicare Part B at the time you reach age 65, you should purchase coverage immediately when you retire or lose coverage as an active employee. Failure to enroll within 7 months may result in delayed eligibility or premium penalties. At the time you lose coverage as an active employee, Medicare becomes your primary health coverage, while this Plan becomes secondary if you are entitled to retiree coverage.

CLAIMS AND APPEALS PROCEDURES

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administration denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

An adverse benefit determination, for the purpose of the internal claims and appeal process, means (i) a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; (ii) a reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or (iii) a rescission of coverage, whether or not there is an adverse effect on any particular benefit.

This section applies to Comprehensive Medical Benefits, Prescription Drug, Dental, Optical, Hearing Aid and Weekly Disability Benefits. See the Empire Blue Cross Blue Shield Section for details on Empires Claims and Appeals procedures.

How to File a Claim

A claim for benefits is your request for Plan benefits made in accordance with the Plan's procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

When you present a prescription to a pharmacy to be filled out under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

You do not have to file a claim form for any in-network services you receive.

Claim Elements

You must submit the following information in order for your request for medical benefits to be a claim, and for the appropriate Health Organization to be able to decide your claim.

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the appropriate Health Organization (as applicable);
- Name a specific individual participant and his/her Social Security Number or alternative ID number;
- Name a specific claimant and his/her date of birth;

- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN);
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim; and
- If treatment is due to accident, accident details.

When Claims Must Be Filed

All Health Claims, except Hospital claims, should be filed within **90 days** following the date you incur the charges. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, you must submit the claim as soon as reasonably possible and **in no event later than one year** from the date the charges were incurred.

You may file a claim for Vacation Benefits at any time during the calendar year.

Where To File Claims

For Hospital Claims, see the *Hospital Benefits* section of this Plan.

Your claim will be considered filed as soon as it is received by the appropriate Claims Administrator responsible for deciding your claim at the applicable address listed below:

For Medical Claims (other than secondary):

Magnacare
P.O. Box 1001
Garden City, NY 11530
Electronic payer ID 11303

For Optical, Dental Hearing Aid, Self-Insured Member's Assistance Program (MAP), and Vacation Benefit Claims:

Iron Workers Locals 40, 361 & 417 Health Fund
451 Park Avenue So.
9th Floor
New York, NY 10016
(212) 684-1586

For Prescription Drug Claims:

Optum Rx
PO Box 29044
Hot Springs, AR 71903
(800) 797-9791

Or for secondary

Iron Workers Locals 40, 361 & 417 Health Fund

451 Park Avenue So.
9th Floor
New York, NY 10016
(212) 684-1586

For All Dental Claims:

Iron Workers Locals 40, 361 & 417 Health Fund
451 Park Avenue So.
9th Floor
New York, NY 10016
(212) 684-1586

For Life Insurance and Accidental Death and Dismemberment Claims, Weekly Disability: Claims are submitted to the Fund Office and then forwarded by the Fund to The Hartford Life Insurance Company. These claims are considered filed when they are received by The Hartford.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. You may obtain a form from the Fund Office or Empire, as applicable, to designate an authorized representative. Additional information to verify that this person is authorized to act on your behalf may be required.

Types of Claims

The claims procedures for benefits will vary, depending on whether your claim is for a **Medical Claims** or a **Disability Claim or Life and Accidental Death and Dismemberment Claim**. Read each section carefully to determine which procedure is applicable to your request for benefits:

Medical Claims:

Pre-Service, Concurrent and Urgent Care Claims

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

A **Concurrent Claim** is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of benefits. In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision treatment.

Currently, the Iron Workers Locals 40, 361 & 417 Health Fund does not provide benefits which require prior approval and all claims are considered Post-Service Claims. However, all services are subject to approval by medical consultants before payment will be made. See the Hospital section for details on how Empire handles claims that pertain to Hospital services.

Post-Service Claim

The following procedure applies to Post-Service Claims. A Post-Service Medical Claim or a non-participating hospital claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

- Obtain a claim form.
- Complete the employee's portion of the claim form.
- Have your Physician or Dentist either complete the Attending Physician's or Attending Dentist's Statement section of the claim form, submit a completed CMS-1500 health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills, doctor's or dentist's statements that describe the services rendered.

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

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any additional bills or statements for any Medical or Hospital services covered by the Plan to the Fund or Empire, respectively, as soon as you receive them. Mail any further bills or statements for any Dental services covered by the Plan to the Fund as soon as you receive them.

Time frame for deciding Post-Service Claims: Ordinarily, you will be notified of the decision on your **Post-Service** Hospital or Medical Claim within *30 days* from receipt of the claim. This period may be extended one time by the Health Organization responsible for deciding the claim for up to *15 days* if the extension is necessary due to matters beyond their control. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision will be rendered.

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

Weekly Disability Claims

A **Weekly Disability Claim** is any claim that requires a finding of total disability as a condition of eligibility. A claim for Weekly Disability benefits must be made to the Fund Office by returning a completed claim form along with proof of disability.

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

If an extension is needed because The Hartford needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be decided on the basis

of the information that the Plan has and it may be denied. During the period in which you are allowed to supply the additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of either 45 days or the date you respond to the request. Once you respond to the Fund's request for the additional information, you will be notified of The Hartford's decision on the claim within *30 days.*

For Weekly Disability Claims, the Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

Claims for Accidental Death and Dismemberment and Life Insurance Benefits

An Accidental Death & Dismemberment (AD&D) claim is any claim for loss of life, limb(s), or sight of eye(s) caused directly and independently by accident.

A Life Insurance claim is any claim made by your beneficiary an occasion of your death.

A claim for Accidental Death and Dismemberment (AD&D) and Life Insurance benefits must be made to the Fund Office by returning a completed claim form, along with the required proofs of dismemberment or death to the Fund Office. You must submit a certified copy of the death certificate for Life Insurance and Accidental Death claims. The Fund Office will then forward the claim to The Hartford.

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

Claims for Vacation Benefits

You can apply for the balance of your Individual Vacation Account at any time. To receive your benefits you must complete a Vacation Fund withdrawal form and file it with the Fund Office.

The Trustees will notify you in writing of their decision about your Vacation Benefits claim within 60 days of receiving it. Under special circumstances, the Trustees may notify you in writing that an additional 60-day extension is needed to process your application. The Trustees will provide you with the reason the extension of time is needed.

Notice of Decision

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). You will be provided with written notice of a denial of your claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge,

- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge, and

- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request.

Payment of Benefits

The Plan pays benefits only for covered expenses that you or your Dependents incur during the time you are covered under the Plan, provided a claim is filed within the applicable time limits. Generally, the Plan will pay the provider directly. However, payment may be made to you if you paid the charges and you submit the claim along with a paid receipt. If the Plan makes payment to you, you are responsible to pay the provider. Once you receive covered services from a provider, you do not have the right to request that the Plan not pay a claim submitted to the Plan by the provider for those covered services. Once the Plan makes payment on a claim, no further payment will be made. You will receive an Explanation of Benefits (EOB) form from the Plan that shows what the Plan has paid. On indemnity plan claims, you are responsible for paying any amounts not paid by the Plan. On Magnacare Plan claims, you are responsible for copayments, coinsurance and expenses not covered by the Plan.

If the Trustees determine that an individual is legally incapable of giving a valid receipt for any payment due and no guardian has been appointed, the Trustees may make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual.

If an individual dies before all amounts due have been paid, the Trustees may, at their option, make such payment to the individual who paid the expenses or to the individual's estate as provided under applicable law.

Any payment made by the Plan fully discharges the liability of the Trustees to the extent of such payment. However, self-insured benefits payable under the Plan are limited to the Plan assets available for payment of such benefits.

If the Plan makes a payment due to mistake or fraud, the Plan is entitled to recover any such payments from you, or to withhold future medical benefit payments otherwise payable to you or your Dependents until any overpayment has been recovered by the Plan.

Appeal Procedure

Filing Your Appeal

If your claim is denied in whole or in part, or if you disagree with the decision made on your claim for Plan benefits, you may ask for a review. Your request for review must be made in writing to the appropriate Health Organization within *180 days* after you receive notice of denial, except for Life Insurance and AD&D claims which have a 60-day time limit for filing an appeal. Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

For Medical, Optical, Dental, Prescription Drug, Hearing Aid, MAP and Vacation Benefit Claim Appeals, the Fund maintains a one-level appeal process.

Send all medical, optical, dental, prescription drug, hearing aid, MAP and Vacation Benefit claim appeals to the Board of Trustees at:

Iron Workers Locals 40, 361 & 417 Health Fund
451 Park Avenue So.
9th Floor
New York, NY 10016
(212) 684-1586

For Insured Weekly Disability Claim Appeals, the Fund maintains a one-level appeal process.

Appeals should be sent to The Hartford at the address found in the "Quick Reference" Chart.

For Life Insurance and Accidental Death and Dismemberment Claim Appeals, The Hartford maintains a one-level appeal process. Send all life insurance and accidental death and dismemberment claim appeals to the Fund Office.

Review Process

The review process works as follows:

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

The Plan will provide you with a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination.

If you request it, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual.

Timing of Notice of Decision on Appeal

- **Hospital Claims: See the Hospital Benefits section regarding How to File an Appeal.**

- **All Other Post-Service Claims:** Decisions on appeals involving Post-Service Medical, Optical, Dental, Prescription Drug, Hearing Aid, and MAP Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

- **Weekly Disability Claims:** The decision will be made in the same manner as for Post-Service Claims.

- **Life and AD&D Claims:** The Hartford will make the decision within 60 days of its receipt of your request for review. Under special circumstances, an extension of time, not exceeding 60 days, may be required. If such an extension is needed, The Hartford will notify you or your beneficiary, in writing before the 60-day period expires, of the special circumstances and the date when a decision will be made. You will receive a written notice of the decision from The Hartford.

- **Vacation Benefit Claims:** The Trustees will make a decision on your appeal within 60 days from the date it is received by them. If unusual or special circumstances prevent the Trustees from making a decision within 60 days, they will notify you that they will use an extension of 60 days to process your appeal.

Voluntary Third Level of Appeal

If your level one and level two hospital claim appeal is denied by Empire, you will have an opportunity to file a voluntary level of appeal before the Board of Trustees.

This level of appeal is **completely voluntary;** it is **not** required by the Plan. The following are the claims procedures pertaining to the voluntary level of appeal:

- The Plan will not assert a failure to exhaust administrative remedies where you or your authorized representative elect to pursue a claim in court rather than through the voluntary level of appeal;

- Where you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;

- The voluntary level of appeal is available only after you or your authorized representatives have pursued the appropriate mandatory appeals process required by the Plan, as indicated previously in this section;

- Upon your request, the Plan will provide you or your authorized representative with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process.

The Plan will not impose fees or costs on you or your authorized representative, should you or your authorized representative choose to invoke the voluntary appeals process. To request this voluntary appeal, or if you have any questions, please call the Fund Office.

Notice of Decision on Review

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

- The specific reason(s) for the determination,
- Reference to the specific plan provision(s) on which the determination is based,
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol was relied upon by the appropriate Health Organization, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on lack of medical necessity, or that the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May be Started

You may not start a lawsuit to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. (For post-service claims, notice that the issue will be decided at the second quarterly Board meeting, or if the Plan received the appeal within 30 days of a Board meeting, the third meeting from receipt.) No lawsuit may be started more than three years after the end of the year in which services were provided (or if the claim is for short term disability benefits, more than three years after the start of the disability). The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them.

Work in Reciprocating Jurisdictions

Brief Explanation of Point of Claim Reciprocity

Point of Claim Reciprocity is an arrangement under the Iron Workers International Reciprocal Health and Welfare Agreement whereby you can maintain your eligibility for benefits under this Plan even though you are working in the jurisdiction of another health fund. The other health fund (a Cooperating Fund), in whose jurisdiction you are working, agrees under certain circumstances to transfer employer contributions it has received on your behalf to this Fund (the Home Fund). Therefore, hours of service with a Cooperating Fund(s) will be considered service with the Home Fund for the purpose of maintaining your eligibility for benefits with the Home Fund, regardless of the dollar amount of the contributions transferred.

For this Fund to be your Home Fund, you must either: (1) be a member of one of the local unions that participate in this Plan and have established your eligibility to be a Plan participant, or (2) have had the largest amount of employer contributions made on your behalf in the preceding 12-month period paid to this Fund. If you change your

membership to another local union that does not participate in this Plan, this Fund will no longer be your Home Fund. The health fund in which your new local union participates would then become your Home Fund.

You should follow the procedures listed below when filing claims for benefits:

1. File claims for benefits with your Home Fund as long as your service with the Home Fund is enough to meet its eligibility requirements, even though you may be working in the jurisdiction of a Cooperating Fund when you file your claim.

2. File claims for benefits with a Cooperating Fund if you have lost your eligibility status with your Home Fund but have been working in the jurisdiction of the Cooperating Fund for a period long enough to meet its eligibility requirements.

3. Where you do not meet the eligibility requirements of either your Home Fund or a Cooperating Fund, you should file claims for benefits with your Home Fund. In this instance, Point of Claim Reciprocity becomes effective. Your service with a Cooperating Fund(s) will be used toward meeting the eligibility requirements of your Home Fund. You will not be entitled to benefits from any of the Funds if your service, including service with Cooperating Funds, is not enough to reestablish eligibility with your Home Fund.

In filing claims for benefits with your Home Fund, indicate all Cooperating Funds in whose jurisdiction you have worked. Contact the Home Fund Office to determine if a welfare fund is a Cooperating Fund with your Home Fund.

If you have worked outside the jurisdiction of this Fund and have or expect to have a medical claim, you should contact the Fund Offices of the other Fund(s) to determine the type of reciprocity to which you are entitled.

HOW BENEFITS ARE COORDINATED

You, your spouse and your other Dependents may be covered through your respective employers by more than one group medical, dental or health insurance plan. In that case, benefits are coordinated between the plans so that you may receive up to but not more than 100% of the scheduled allowance for which you submit claims for covered services. This Plan does not coordinate benefits with an individual plan, including a plan purchased through the Health Insurance Marketplace. These provisions apply to the medical benefits. See *Hospital Benefits* section for the coordination of benefits provisions applicable to hospital benefits.

How Coordination of Benefits Works

When benefits are coordinated, one plan is designated the primary plan, the other is secondary. The primary plan pays first. Then, the secondary plan pays a reduced amount that, when added to the benefits paid by the primary plan may reach up to 100% of the scheduled allowance for a covered health care service in your geographical area. For purposes of these rules, another "plan" means any plan providing benefits or services for hospitalization, surgical, medical or dental treatment that are provided through group insurance or by another arrangement of coverage for individuals in a group whether on an insured or uninsured basis.

To administer this provision properly, and to determine whether this Plan will reduce its regular benefit, it is necessary to determine the order in which the various group plans will pay benefits. Here is the order in which benefits will be determined:

A plan with no provision for coordination of other benefits will be considered to pay its benefit before a plan that contains such a provision.

1. ***Non-Dependent or Dependent***: A plan that covers a person other than as an eligible dependent (e.g., as an employee) will be considered to pay its benefit before a plan that covers the individual as an eligible dependent.

2. ***Dependent Children Covered Under More than One Plan:***

   a. For dependent children covered by both parents' plans, the plan covering the parent whose birthday falls earlier in the year (month and day) pays first if: (i) the parents are married; (ii) the parents are not separated (whether or not they ever have been married); or (iii) a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child. The plan covering the parent whose birthday falls later in the year pays second.

      If both parents have the same birthday, the plan that covered a parent longer pays first. The plan that covered the other parent for a shorter time pays second. A person's year of birth is not used in applying this rule.

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

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

c. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the Plans of the parents and their Spouses (if any) is:

   i. The plan of the custodial parent pays first; and

   ii. The plan of the Spouse of the custodial parent pays second; and

   iii. The plan of the non-custodial parent pays third; and

   The plan of the Spouse of the non-custodial parent pays last.

d. If the child has employer-sponsored coverage as an active employee through his or her own employment and is also covered through both of his parents, the child's plan pays first and the parents' plan will pay second and third, in accordance with (a) through (c) of this rule, provided that allowable expenses remain.

e. If the child has employer-sponsored coverage as an active employee and is married and also has employer-sponsored coverage through his or her spouse's employment, the child's plan pays first and the spouse's plan pays second. The parents' plan will pay third (and fourth, if applicable), in accordance with (a) through (c) of this rule, provided that allowable expenses remain.

Active/Laid-Off or Retired Employee

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

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

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

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

- The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.

- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

- If the other coordinating plan determines benefits on the basis of Allowed Charges, this Plan will use the Allowed amount as the allowable expense.

- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

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

Administration of the Coordination of Benefits

1. To administer the Coordination of Benefits (COB), the Plan reserves the right, in accordance with the HIPAA Privacy Rules to:

    a. exchange information with other plans involved in paying claims;

    b. require that you or your Health Care Provider furnish any necessary information;

    c. reimburse any plan that made payments this Plan should have made; or

    d. recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

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

4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

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

may be determined based on the prevailing rates for such services in the community in which the services were provided.

6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan. When this Plan pays second, it will pay the applicable percentage of either 1) the Plan's "Allowable Expense" less payments were actually made by the plan or plans that paid first; or 2) covered individual's remaining responsibility to a participating provider under the first plan for "Allowable Expenses".

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

Coordination of Benefits under Medicare and Other Government Programs

Medicare

Generally, anyone age 65 or older is entitled to enroll in Medicare coverage. Medicare Part A (Hospital) coverage is automatic and is provided without charge. You may choose to enroll in Medicare Part B (physician coverage) or you may choose a Medicare Advantage program, which is Medicare's managed care HMO offering. You may also choose to enroll in Medicare Part D, which is Medicare's prescription drug coverage program. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to enroll in Medicare coverage after a waiting period. Be sure to read the section entitled "If You Continue to Work After Age 65" shown in this document.

- If you, your covered Spouse or Child becomes covered by Medicare, either because of disability or age, you may either retain or cancel your coverage under this Plan.

- If you, your spouse and/or your Child are covered by this Plan and by Medicare, and you retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same benefits and your contributions for coverage will remain the same, and this Plan pays first and Medicare pays second. If you are not actively employed, then Medicare pays first and this Plan pays second.

- If you are actively employed and are covered under Medicare Part D, you, your Spouse and/or your Child retain coverage under this Plan, as long as you remain actively employed. Your prescription drug coverage will continue to provide the same benefits and your contributions for coverage will remain the same, however this Plan pays first and Medicare pays second.

- This Plan does not pay prescription drug benefits on behalf of retirees that are eligible for Medicare Part D, but instead reimburses the premiums paid by retirees and spouses for participating in a Medicare Part D plan.

- If you cancel your coverage under this Plan, coverage of your spouse and/or your Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage.

However, if you become totally disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second. In addition, the Fund will not be the primary carrier for you if you work for an employer that does not have 20 or more employees.

If while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

- The month in which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

How Much This Plan Pays When It Is Secondary to Medicare

When the Participant Is Covered by this Plan and also by Medicare Parts A and/or B: When the plan participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the Medicare coinsurance and/or deductible up to the Medicare allowable amount. Benefits payable by this Plan are based on the fees allowed by Medicare and not on billed charges of the Health Care Provider. Medicare will not pay for any drugs that Medicare does not pay for, including drugs that Medicare considers non-formulary.

When the Participant Is Covered by this Plan and also by a Medicare Advantage Program (Formerly called Medicare + Choice or Part C): This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a Plan Participant is covered by a Medicare Advantage program and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active Employees less any amounts paid by the Medicare Advantage Program. This applies to the prescription drugs covered by the Medicare Advantage Plan.

However, if the Plan Participant does not comply with the rules of the Medicare Advantage program, including without limitation, approved referral, preauthorization, or case management requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Plan Participant receives.

When the Participant Is Covered by this Plan and Eligible for but Not Covered by Medicare: If the Plan Participant is eligible for but not enrolled in Medicare, this Plan pays the Medicare co-insurance and /or deductible up to the Medicare allowable amount. Benefits payable by this Plan under this provision are based on the fees allowed by Medicare.

When the Participant is Covered by this Plan and also Enters Into a Medicare Private Contract: Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan: If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:

> For Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

For more information on Medicare Part D refer to www.medicare.gov or contact the Fund Office.

Medicaid

Benefits are not coordinated with Medicaid.

TRICARE

If a covered individual is covered by both this Plan and TRICARE, this Plan pays first and TRICARE pays second. (TRICARE is a government-sponsored insurance program for military veterans and some federal employees.)

Veterans Affairs/Military Medical Facility Services

If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

Health Insurance Marketplace

This Plan does not coordinate benefits with an individual plan, including a plan purchased through the Health Insurance Marketplace.

Motor Vehicle No-Fault Coverage Required by Law

If a covered individual is covered for medical and/or dental benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

Other Coverage Provided by State or Federal Law

If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Workers' Compensation

This Plan does not provide any Benefits for expenses covered by Workers' Compensation or occupational disease law.

If the company contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, you and/or your covered Dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee.

SUBROGATION

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

Liens, Law Suits, and Other Compensable Sources

In consideration of any benefit payments made by the Plan, you or your Dependents will subrogate (assign) to the Plan your right of recovery against any person or organization and any action in tort to the extent of the amount of your or your Dependent's claim. In other words, if someone negligently injures you and the Plan provides you with benefits to care for that injury, you must reimburse the Plan out of whatever you may recover from the wrongdoer.

> ***For Example:***
>
> An employee and his spouse are injured in an automobile accident that was John Johnson's fault. If the Plan paid $1,000 in benefits to the employee and/or his spouse due to injuries resulting from the accident, and the employee or his spouse was entitled to recover or did recover, due to a legal suit or settlement, any money from John Johnson, the Plan would be entitled to receive up to $1,000 of such money as reimbursement for the benefits which it provided to the employee or his spouse.

You or your Dependents must not do anything after the loss for which the Benefits were provided that interferes with or otherwise prejudices the Fund's right of recovery. You must promptly advise the Plan Administrator in writing whenever a claim against any party is made by or on your behalf or on behalf of your Dependents with respect to any loss for which your received benefits from the Plan.

You and your Dependents must provide the Plan Administrator with the names and addresses of all potential parties and their insurers, adjusters, and claim numbers, as well as accident reports and any other information the Fund requests. If you do not provide the information, the Fund may withhold future benefit obligations pending receipt of the requested information. You and your Dependents or the Plan may make a claim against a party as provided applicable state or federal law. Both you and the Plan will have an equal voice in the prosecution of such claim or action.

The proceeds from any settlement or judgment received by you or your Dependent in any claim made against any party will be allocated as follows:

> **First,** a sum sufficient to fully reimburse the Plan for all benefits advanced must be paid to the Plan, with no deduction of court costs or attorneys fees, unless the Plan gave written consent to such a deduction. The Plan's right to this recovery will not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorneys' Fund Doctrine" or any other doctrine or theory.
>
> **Second,** any remainder will be paid to your or your Dependent.
>
> **Third,** the Plan will receive a credit, up to the full amount of any remainder the Plan paid to you or your Dependent to apply against any future benefit obligations arising out of the injury, sickness or death that was the subject of the claim resulting in the settlement or judgment.

The allocation of the proceeds of any recovery will be paid from the first dollar of any proceeds received and will have priority over competing claims, regardless of whether the total amount of your recovery is less than the actual loss suffered, or less than the amount necessary to make you whole. The Fund's rights will not be defeated or reduced by the application of any "Made-Whole Doctrine," "Garrity Doctrine," "Rimes Doctrine," or any other

doctrine purporting to defeat the Fund's right by allocating the proceeds exclusively, or in part, to non-medical expense damages.

If you or your Dependent makes a recovery in a claim from any party and the proceeds are not allocated as required, the Trustees have the right to make a claim for reimbursement, including, but not limited to, claims for restitution, unjust enrichment, or a constructive trust over any recovery by you or your Dependent, to the extent of the Plan's expenditures, whether the recovery is paid to, or in the possession of you or your Dependent, your attorney, or any other individual or entity, or to take a credit on future Plan obligations to your or your Dependent. Such credit will not be limited to future obligations of the Plan to the actual recipient of such benefits, but also may be taken against any future obligations to you or your Dependents.

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

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

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

B. Reimbursement [and/or Subrogation] Agreement

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

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that**

Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.

C. **Cooperation with the Plan by All Covered Individuals**

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

1. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and

2. that the Plan has the first right of reimbursement from any judgment or settlement; and

3. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and

4. to not assign the right of recovery to any third party without the specific consent of the Plan; and

5. to notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and

6. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. **Subrogation**

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

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

   a. start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or

   b. intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

E. Application to Any Fund

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

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

    b. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

F. Lien and Segregation of Recovery

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

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

3. Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

G. Remedies Available to the Plan

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

1. apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or

2. obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded healthcare services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Allowed Amount/Allowed Charge/Allowed Amount/Allowable Charge/Scheduled Allowance for Medical and Dental Benefits: means the amount this Plan allows as payment for eligible medically necessary covered services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to a Network provider, Allowed Charge amount means the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/facility and the network or the Plan; or

2. With respect to a Non-Network provider, Allowed Charge amount means [the schedule that lists the dollar amounts the Plan has determined it will allow] [150% of the amount Medicare would have allowed] for eligible medically necessary covered services or supplies performed by Non-Network providers.

3. For a network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as a network claim; or

4. The negotiated discounted amount that a non-network provider agreed to, reducing the provider's original billed charges to a lower, discounted amount; or

5. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable deductible, copay and/or coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies. This difference (or balance) between the Plan's Allowed Charges and what the provider actually charged (the billed charges) is commonly referred to as "balance billing". Amounts associated with balance billing are not covered by this Plan, even if the Plan's out-of-pocket limit is reached. Out-of-Network Health Care Providers commonly engage in balance billing. Typically, Network providers do not balance bill except in situations of third party liability claims. Generally, you can avoid balance billing by using Network providers.

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

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual out-of-pocket limt. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

The Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a utilization management company, claims administrator/PPO, attorney, stop loss

carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, network/non-network plan design, and any special reimbursement provisions adopted by the Plan.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Mental Health Disorders: Disorders, conditions and diseases as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-g-CM) manual, which includes, among other things, autism, depression, schizophrenia, and Substance Abuse. Certain Mental Health Disorders, conditions and diseases are specifically excluded from coverage in the Exclusions chapter of this document. See also the definition of Substance Abuse.

Calendar Year: The 12-month period beginning January 1 and ending December 31. All annual Deductibles and Annual Maximum Plan Benefits are determined during the calendar year

Chiropractor: A person who:

1. Holds the degree of Doctor of Chiropractic (DC); and

2. Is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and

3. Acts within the scope of his or her license; and

4. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Coinsurance: That portion of Eligible Medical and Dental Expenses for which the covered employee has financial responsibility. In most instances, you are responsible for paying a percentage of covered medical expenses in excess of the Plan's deductible, but in some instances, you are responsible for paying a higher percentage of those expenses, and in other instances, no coinsurance applies.

Convalescent Care Facility: See the definition of **Skilled Nursing Facility**.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan Benefits are payable when a person is covered by two or more employer-sponsored health care plans.

Copayment, Copay: The set dollar amount you are responsible for paying when you incur an Eligible Medical or Dental Expense for certain services, generally those provided by network Health Care Practitioners, Hospitals (or emergency rooms of Hospitals). Or Specialized Health Care Facilities.

Covered Individual: Any employee, member, and/or retiree, and that person's Spouse or Child who is enrolled for coverage under the Plan and is actually covered by the Plan.

Covered Medical and/or Dental Expenses: See the definition of **Eligible Medical and/or Dental Expenses**.

Custodial Care: Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately

(in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay Benefits.

1. Individual Deductible: The amount one covered person must pay before the Plan begins to pay Benefits for that person.

2. Family Deductible: The amount that all covered family members must pay before the Plan begins to pay Benefits for the family members.

The Deductible applies only once in any calendar year even though there may have been several different injuries or diseases. If part or all of the deductible is satisfied during the last three months of any calendar year (October, November, December), any expenses incurred during the next calendar year will be reduced by this amount instead of the full deductible being applied.

Dental: Dental services and supplies are not covered under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise. As used in this document Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics, (but not including prescription drugs), prescribed by a Dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat:

- Teeth;

- The gums and tissues around the teeth;

- The parts of the upper or lower jaws that contain the teeth (the alveolar, processes and ridges);

- The jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint);

- Bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or

- Teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who:

1. Is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered; **and**

2. Acts within the scope of his or her license; **and**

3. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dependent: See “Dependent Eligibility” section for a definition of Dependent.

Disability or Disabled (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of **Totally Disabled**.

Durable Medical Equipment: Equipment that:

1. Can withstand repeated use; and

2. Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and

3. Is not disposable or non-durable.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails) electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of **Orthotic Appliance (or Device) and Prosthetic Appliance (or Device**).

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physicians convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical and/or Dental Expenses: Expenses for medical and/or dental services or supplies, but only to the extent that:

1. They are Medically Necessary, as defined in this Definitions chapter of the document; **and**

2. The charges for them are within the Plan's scheduled allowance as defined in this Definitions chapter of the document; **and**

3. Coverage for the services or supplies is not excluded, as provided in the Exclusions and Dental chapters of this document; **and**

4. The General Overall, Limited Overall, Annual Maximum and/or Maximum Benefit for those services or supplies has not been reached.

Emergency (Dental): A sudden unexpected onset of a dental condition that manifests itself by such acute symptoms of sufficient severity that urgent and immediate dental attention is required to provide relief from pain and prevent serious impairment of dental functions or lead to serious and/or permanent impairment or dysfunction of another body organ or part, or because the patient's life may be threatened.

Emergency (Medical): A sudden unexpected onset of a medical condition, not normally treatable in a Physician's office, that manifests itself by such acute symptoms of sufficient severity that urgent and immediate medical attention is required without regard to the time of day or night either to prevent serious impairment of body functions or serious and/or permanent impairment or dysfunction of any body organ or part, or because the patient's life is threatened.

Emergency Hospitalization or Confinement: A Hospital admission that takes place within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Exclusions, Dental, and Short-Term Disability Benefits Coverage chapters of this document, for which the Plan does not provide Plan Benefits.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Utilization Management program any of the following conditions were present with respect to one or more essential provisions of the service or supply**:

1. The service or supply is described as an alternative to more conventional therapies in the protocols or consent document of the Health Care Provider that performs the service or prescribes the supply;

2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

Gene Therapy: Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Plan does not cover any charges related to gene therapy, whether or not those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well and Luxturna and Zolgensma, but new applications for gene therapies are submitted every year.

Health Care Practitioner: A Physician, licensed psychologist (PhD), mental health or substance abuse counselor or social worker who has a Master's degree), licensed clinical social worker, certified registered nurse anesthetist(CRNA), Chiropractor, Dental Hygienist, Dentist, Nurse Practitioner, Licensed Midwife, Certified Nurse Midwife, Physician Assistant (PA), Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Acupuncturist (who is either a licensed physician, licensed chiropractor, licensed acupuncturist, or an acupuncturist certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)), Master's prepared Audiologist, Optometrist, Optician for vision plan benefits, who:

1. Is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and

2. Acts within the scope of his or her license and/or scope of practice; and

3. Is not the patient or the parent, spouse, sibling (by birth or marriage), aunt/uncle or child of the patient or covered Employee.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Heath Care Agency as defined below.

Home Health Care Agency: An agency licensed or certified and operating according to law that meets all of the following requirements:

1. It primarily provides skilled nursing and other therapeutic services under the supervision of Physicians or Registered Nurses; **and**

2. It is run according to rules established by a group of professional medical providers including Physicians and Registered Nurses: **and**

3. It maintains clinical records on all patients: **and**

4. It is licensed by the jurisdiction where it is located if licensure is required, and operates according to the laws of that jurisdiction pertaining to agencies providing Home Health Care; **and**

5. It is certified by Medicare.

Hospice: A facility or organization licensed and operating according to law and certified by Medicare that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting, with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHHO) and that provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to law. Any portion of a Hospital used as a Skilled Nursing Facility or residential treatment facility or place for rest, Custodial Care, or the aged will not be regarded as a Hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan. However, infertility is not an Illness for the purpose of coverage under this Plan.

In-Network Services: Services provided by a Health Care Provider that is a member of the MagnaCare or Metrodent Network, as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is not a member of the MagnaCare or Metrodent Network.

Medically Necessary:

1. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:

    a. Is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or a Dentist if a dental service or supply is involved; **and**

    b. Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; **and**

    c. Is determined by the Plan Administrator or its designee to meet all of the following requirements:

i. It is consistent with the symptoms or diagnosis and treatment of an illness or injury; **and**

ii. It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; **and**

iii. It is an "Appropriate" service or supply given the patient's circumstances and condition; **and**

iv. It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and

v. It is safe and effective for the illness or injury for which it is used.

2. A medical or dental service or supply will be considered to be "**Appropriate"** if

a. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as; **and**

b. No more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

c. It is care or treatment that is: as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

3. A medical or dental service or supply will be considered to be "**Cost Effective**" if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

4. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

5. A Hospitalization or confinement to a Specialized Health Care Facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and Appropriately be diagnosed or treated while not confined.

6. A medical or dental service or supply that can safely and Appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Specialized Health Care Facility or other more costly facility.

7. The non-availability of a bed in another Specialized Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Specialized Health Care Facility is Medically Necessary.

8. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, or any Hospital or Specialized Health Care Facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Disorder; Mental and Nervous Disorder: See the definition of Mental Health Disorder.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who:

1. Acts within the scope of his or her license; and

2. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Orthotic Appliance (or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does not include Dental Orthotics.

Out-of-Pocket Maximum: The maximum amount of Coinsurance each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional Covered Expenses for the remainder of the Calendar Year. The Plan's Deductible, and any expenses for medical services or supplies that are not covered by the Plan, and all charges in excess of the scheduled allowance as determined by the Plan Administrator or its designee do not count toward the Out-of-Pocket Maximum.

Outpatient Services: Services provided either outside of a Hospital or Specialized Health Care Facility setting or at a Hospital or Specialized Health Care Facility when room and board charges are not incurred.

The Allowance payable by this Plan is set by the Trustees at a prescribed level and this level may be adjusted from time to time by the Trustees in their sole and absolute discretion. The maximum Allowance for MagnaCare in-network providers is determined according to the negotiated rate between MagnaCare and the provider.

This schedule of allowances is maintained by the Fund Office and the amount allowable by the Plan for specific services or procedures is available upon request.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who:

1. Acts within the scope of his or her license; and

2. Is not the patient or the parent, spouse, sibling (by birth or marriage); or

3. Is not the child of the patient.

Podiatrist: A person legally licensed as a doctor of podiatric medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered who:

1. Acts within the scope of his or her license; and

2. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pre-Admission Testing: Laboratory tests and X-rays and other Medically Necessary tests per formed on an out-patient basis prior to a scheduled Hospital admission or out-patient Surgery.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, corrective lenses needed after cataract surgery. For the purposes of the Medical Plan, this definition does not include Dental Prostheses or hair replacements including, but not limited to, wigs, toupees, hair pieces or hair implants.

Qualified Medical Child Support Order (QMCSO): A court or state administrative agency order that complies with requirements of federal law requiring an employee to provide health care coverage for a Child, and requiring that Benefits payable on account of that Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Child.

Reconstructive Surgery: A Medically Necessary Surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy on account of a malignancy.

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; **and**

2. It maintains on its premises all facilities necessary for medical care and treatment; **and**

3. It provides services under the supervision of Physicians; **and**

4. It provides nursing services by or under the supervision of a licensed Registered Nurse, with one licensed Registered Nurse on duty at all times; **and**

5. It is not (other than incidentally) a place for rest, domiciliary or custodial care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, or mentally deficient; **and**

6. It is not a hotel or motel.

Specialized Health Care Facilities: For the purposes of this Plan, Specialized Health Care Facilities include Ambulatory Surgical Facilities, Mental Health Treatment Facilities, Birthing Centers, Hospices, and Skilled Nursing Facilities.

Substance Abuse: Alcohol and/or drug dependency as defined by the current edition of the ICD-g-CM manual.

Surgery:

1. Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits.

2. When the procedures will be considered to be separate procedures, the following percentages of the scheduled allowance will be allowed as the Plan's Benefit:

   a. Allowances for multiple Surgeries through the same incision or operational field:

Primary procedure	90% of Scheduled Allowance
Secondary and additional procedures	50% of Scheduled Allowance

   b. Allowances for multiple Surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	90% of Scheduled Allowance
First site secondary and additional procedures	50% of Scheduled Allowance per procedure
Second site primary and additional procedures	50% of Scheduled Allowance per procedure

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with the Company as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of **Disability**.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child through age 6 that are determined by the Plan to be Medically Necessary even though they are not provided as a result of illness, injury or congenital defect.

POWERS AND DUTIES OF THE TRUSTEES

Plan Amendments or Termination

The Trustees of the Iron Workers Locals 40, 361 and 417 Health Fund reserves the right to amend or terminate this Plan, or any part of it at anytime. Amendments may be made in writing by the Trustees and become effective on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by its Board of Trustees and new coverage may be added by its Board of Trustees. Upon termination of the Plan, the Trustees will apply the monies of the Fund to provide benefits or otherwise to carry out the purpose of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed.

You will be notified in writing of any amendment to the Plan.

Discretionary Authority of the Plan Administrator and Its Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, and will be accorded judicial deference in any action at court, unless it can be shown that the interpretation or determination was arbitrary and capricious.

No Liability for the Practice of Medicine

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

Facility of Payment

If the Fund Administrator determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Fund Administrator, Board of Trustees, appropriate Health Organization nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

GENERAL PLAN INFORMATION

Fund Administrator

The Iron Workers Locals 40, 361 and 417 Health Fund is administered by a joint Board of Trustees composed of Employer Trustees and Union Trustees as listed at the beginning of this document.

Agent for Service of Legal Process

The Board of Trustees is designated as the agent for service of legal process in accordance with ERISA (Employee Retirement Income Security Act) regulations. The business address and telephone number of the Board of Trustees are:

Iron Workers Locals 40, 361 and 417 Health Fund
451 Park Avenue South, 9th Fl.
New York, New York 10016
(212) 684-1586

In addition, service of legal process may be made upon any one Plan Trustee at the above address.

For disputes arising under the portions of the Plan insured by The Hartford, service may be made upon that organization at one of its local offices, or upon the supervisory official of the insurance department in the state in which you reside.

Plan Identification Numbers

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 13-5622663. The Plan number is 501.

Official Name of Plan

Iron Workers Locals 40, 361 and 417 Health Fund

Type of Plan

This Plan is an Employee Health Benefits Plan that includes hospital expense benefits, medical expense benefits, prescription drug expense benefits, dental expense benefits, optical expense benefits, hearing aid expense benefits, disability expense benefits, death expense benefits, accidental death and dismemberment expense benefits and vacation benefits.

Benefits Are Not Vested and Do Not Guarantee Employment

Your coverage by this Plan does not constitute a guarantee of your continued employment and you are not vested in the benefits described in this booklet. All Plan benefits are made available to you and your Dependents by the Plan as a privilege and not as a right.

Income and Reserves

The Iron Workers Locals 40, 361 and 417 Health Fund is maintained through collective bargaining agreements between the Local Unions 40, 361 and 417 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers (AFL-CIO) and the participating employers.

These collective bargaining agreements provide that employers contribute to the Fund on the basis of a fixed rate per hour paid in accordance with the applicable collective bargaining agreement.

The Fund Office will provide you, upon written request, with a copy of the applicable collective bargaining agreement and information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreement.

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to covered participants and for defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies with Empire and the The Hartford.

The Fund's assets and reserves are held in custody and invested by registered investment managers.

Fiscal Year

For purposes of maintaining the Fund's fiscal records, the fiscal year ending date of the Plan is December 31.

Type of Administration for Medical, Optical, Dental, Hearing Aid and Vacation Benefits

Comprehensive Medical Expense benefits, Optical Benefits, Dental Benefits, Hearing Aid benefits, and Vacation benefits are provided by the Health Fund on a self-insured basis. The Fund Office administers the Comprehensive Medical Expense, Optical, Dental, Hearing Aid and Vacation benefits.

Type of Administration for Hospital Benefits

Hospital benefits are self-insured by the Fund, but administered by Empire BlueCross.

Type of Administration for Prescription Drug Benefits

Prescription drug benefits for non-Medicare eligible benefits are offered by the Health Fund on a self-insured basis. Optum Rx administers the Prescription Drug Benefits. The prescription drug benefit for Medicare eligibles are insured and administered through Silver Script.

Type of Administration for Life, Accidental Death and Dismemberment and Weekly Disability Benefits

The Hartford Life Insurance Company insures the Life Insurance, Accidental Death and Dismemberment Insurance and Weekly Disability benefits.

Policy and Certificate

The complete terms of the coverage for Life Insurance, Accidental Death and Dismemberment Insurance, Weekly Disability and Hospital benefits are set forth in the group insurance policies issued by the The Hartford.

Plan Administrator and Plan Sponsor

The Plan is sponsored and administered by the Board of Trustees of the Iron Workers Locals 40, 361, and 417 Health Fund, consisting of an equal number of union and employer Trustees. Although the Board of Trustees is legally designated as the Plan Administrator, the Trustees have delegated many of the day-to-day administrative functions to the Fund Office located at:

Iron Workers Locals 40, 361, and 417 Health Fund
451 Park Avenue South, 9th Fl.
New York, New York 10016

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Iron Workers Locals 40, 361 and 417 Health Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants will be entitled to:

Receive Information about Your Plan and Benefits

You have the right to:

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

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

- Receive a summary of the Plans annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive vacation benefits and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse or Child(ren) if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse or Child(ren) may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a health fund 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 Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file 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 domestic relations order or 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 the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefit Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Employee Benefits Security Administration (EBSA). For single copies of publications, contact the EBSA Brochure Request Line at 866-444-3272 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions at the EBSA website at http://www.dol.gov/ebsa/.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that the Health Fund maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, and Family and Medical Leave (FMLA).

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Fund Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan will not use or further disclose information that is protected by HIPAA (protected health information or PHI) except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

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

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

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

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

     - Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits,

subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

- Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

B. **Health Care Operations** includes, but is not limited to:

1. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

3. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

5. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

6. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

C. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Fund Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

D. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,

2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as

Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.

3. Not use or disclose the information for employment-related actions and decisions,

4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

6. Make PHI available to the individual in accordance with the access requirements of HIPAA,

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

8. Make available the information required to provide an accounting of PHI disclosures,

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

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

1. The Plan Administrator,

2. Staff designated by the Plan Administrator

3. Business Associates under contract to the Plan including but not limited to Magnacare, SIDS/Metrodent, The Hartford, Davis Vision, General Vision Services and Comprehensive Professional Services,

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

G. In compliance with **HIPAA Security** regulations, the Plan Sponsor:

1. Has implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Will ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

H. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules.

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