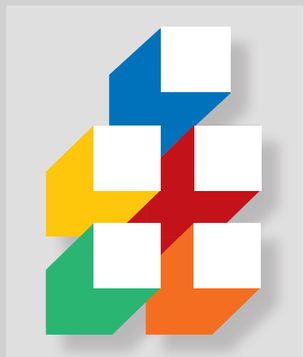
32BJ North Health Fund
25 West 18th Street
New York, New York 10011-4676
Telephone 1-800-551-3225
www.32bjfunds.org

32BJ North Health Fund



Summary Plan Description

January 1, 2015

Tri-State Preferred North Plan

Translation Notice

This booklet contains a summary in English of your Plan rights and benefits under the 32BJ North Health Fund. If you have difficulty understanding any part of this booklet, contact Member Services at 1-800-551-3225 for assistance or write to:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

The office hours are from 8:30 a.m. to 5:00 p.m., Monday through Friday. You may also visit www.32bjfunds.org.

Este folleto contiene un resumen en inglés de sus derechos y beneficios con el Plan del 32BJ North Health Fund. Si tiene alguna dificultad para entender cualquier parte de este folleto, contacte al Centro de servicios para afiliados al 1-800-551-3225 para recibir asistencia, o escriba a la dirección siguiente:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

El horario de oficina es de 8:30 a.m. a 5:00 p.m., de lunes a viernes. También puede visitar www.32bjfunds.org.

Kjo broshurë përmban një përmbledhje në anglisht, në lidhje me të drejtat dhe përfitimet tuaja të Planit nën 32BJ North Health Fund. Nëse keni vështirësi për të kuptuar ndonjë pjesë të kësaj broshure, kontaktoni Shërbimin e Anëtarit në numrin 1-800-551-3225 për ndihmë ose mund të shkruani tek:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

Orari zyrtar është nga ora 8:30 deri më 17:00, nga e hëna deri të premten. Gjithashtu, ju mund të vizitoni faqen e Internetit www.32bjfunds.org.

Niniejsza broszura zawiera opis, w języku angielskim, Twoich praw i świadczeń w ramach Planu 32BJ North Health Fund. W przypadku jakichkolwiek trudności ze zrozumieniem dowolnej części broszury, prosimy skontaktować się z Centrum obsługi członków pod numerem telefonu 1-800-551-3225 lub pisemnie na adres:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

Biuro czynne jest w godzinach od 8:30 do 17:00 od poniedziałku do piątku. Można również odwiedzić naszą stronę pod adresem www.32bjfunds.org.

Contact Information

What do you need?	Who to contact	How
• General information about your eligibility and benefits • Information on your hospital, medical, vision, dental and disability benefits and claims	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday, or Visit the Welcome Center at 25 West 18th Street New York, NY 8:30 am–6:00 pm Monday–Friday
• To find a 5 Star Center • To find a primary care **physician** • To find participating Empire BlueCross BlueShield providers	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday or Visit www.32bjfunds.org
• To find a participating dental plan provider	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday, or Dental: Visit www.asonet.com
• To find a participating vision plan provider	Davis Vision	Call 1-800-999-5431 8:00 am–11:00 pm, Monday–Friday Saturday, 9:00 am–4:00 pm Sunday, 12:00 pm–4:00 pm Visit www.32bjfunds.org
• Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com
• To pre-certify a hospital or medical stay	Empire BlueCross BlueShield	Providers call 1-800-982-8089
• To pre-certify mental health or substance abuse stay	Empire BlueCross BlueShield	Providers call 1-855-531-6011
• To help prevent or report health insurance fraud (hospital or medical)	Empire Fraud Hotline	Call 1-800-423-7283 9:00 am–5:00 pm, Monday–Friday
• Information about your prescription drug benefits, formulary listing or participating pharmacy	CVS Caremark	Call 1-877-765-6294 or Visit www.Caremark.com 24 hours a day/7 days a week
• Immediate medical advice	Nurses Healthline	Call 1-877-825-5276 24 hours a day/7 days a week
• Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc.	Empire BlueCross BlueShield	Call 1-212-388-3660

32BJ North

Health Fund

25 West 18th Street, New York, NY 10011-4676
Telephone: 1-800-551-3225

The 32BJ North Health Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

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Important Notice

This booklet is both the Plan document and the Summary Plan Description ("SPD") of the plan of benefits ("the Plan") of the 32BJ North Health Fund's ("the Fund") Tri-State Preferred North Plan of benefits for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The terms contained herein constitute the terms of the Plan.[(1)] Your rights to benefits can only be determined by this SPD, as interpreted by official action of the Board of Trustees ("the Board"). You should refer to this booklet when you need information about your Plan benefits. In addition, the Board reserves the right, in its sole and absolute discretion, to amend the Plan at any time.

In the event of conflict or ambiguity between this SPD and your collective bargaining agreement, this SPD will control. Also in the event there is any conflict between the terms and conditions for the Plan benefits as set forth in the SPD and any oral advice you receive from a Building Service 32BJ Benefit Funds employee, union representative, or **employer,** the terms and conditions set forth in this booklet control.

- Save this booklet – put it in a safe place. If you lose a copy, you can ask Member Services for another or obtain it from www.32bjfunds.org.
- If you change your name or address – notify Member Services immediately by calling 1-800-551-3225 so your records are up-to-date.
- Words that appear in **boldface** print are defined in the Glossary.
- Throughout this booklet, the words "you" and "your" refer to participants whose employment makes them eligible for Plan benefits.

[(1)] This SPD is the plan document for the Tri-State Preferred North Plan, which includes the hospital, medical, mental health and substance abuse, prescription drug, dental, vision, life insurance and accidental death and dismemberment benefits, and short-term disability benefits. Insurance contracts from MetLife and, effective June 1, 2015, Guardian Life Insurance Company of America ("Guardian"), are the plan documents for the Life and Accidental Death & Dismemberment Insurance and Short-Term Disability Plans. The plans and the benefits they pay are limited by all the terms, exclusions, and limitations of those contracts in force at the time of the covered incident. The Board reserves the right to change insurance carriers and contracts. If the Board makes any such changes, the benefits coverage described in this SPD may not be accurate. You may request copies of the insurance contracts from MetLife and Guardian.

The word "dependent" refers to a family member of a participant who is eligible for Plan benefits. In the sections describing the benefits payable to participants and dependent(s), the words "you" and "your" may also be used to refer to the patient.

- This booklet describes the provisions of the Plan in effect as of January 1, 2015, except as otherwise noted.

Frequently Asked Questions

1. What benefits does the Plan provide?

The Plan provides a comprehensive program of benefits, including:

- hospital,
- medical,
- mental health and substance abuse,
- prescription drug,
- dental,
- vision,
- life insurance,
- accidental death and dismemberment, and
- short-term disability benefits.

Each of these benefits is described in detail later in this booklet.

2. What do I have to do to cover my dependent(s)?

- Fill out and return the appropriate form, and
- Provide documentation that proves the individual you want to enroll is your dependent. For example, you must provide a marriage certificate to cover your spouse or a birth certificate for a dependent child.

You can get forms from:

- The website www.32bjfunds.org
- Member Services by calling 1-800-551-3225.

3. What happens if I get married or have a baby?

You must:

- Notify the Fund within 30 days of the date of marriage or birth,
- Fill out and return the appropriate form, and
- Provide documentation proving the relationship.

If you notify the Fund within 30 days, your dependent will be covered from the date of the event (birth, adoption, marriage). If you do not notify the Fund within 30 days of the event, your spouse/child will only be covered prospectively from the date you notify the Fund.

4. How do I know if my doctor is in-network?

To find out if your **doctor** is in the Empire BlueCross BlueShield Direct Point-of-Service ("POS") **network**:[2]

- Visit the website www.32bjfunds.org, or
- Call Member Services at 1-800-551-3225.

5. What is my out-of-pocket cost to see a network doctor?

There are two types of **doctors** in the **network**: 5 Star Center providers and **participating providers**. 5 Star Center providers are providers who have earned certification as a Patient-Centered Medical Home from the National Committee for Quality Assurance ("NCQA") and who have agreed to work with the Fund. If you receive care at a 5 Star Center, you will pay the least amount. See below:

	5 Star Center Providers	**Participating Providers**
Doctor Office Visits	$0 **co-payment**/visit	$40 **co-payment**/visit

6. What happens when I need care away from home?

You are covered. Make sure you use a **participating provider** in a local BlueCross BlueShield **network**.

7. How do I find a 5 Star Center provider with a $0 co-payment?

- Visit the website www.32bjfunds.org, or
- Call Member Services at 1-800-551-3225.

8. What happens if I see a non-participating doctor?

You will pay more. You will have to pay:

- $500 (the annual **deductible**),
- 50% of the **allowed amount**, and
- All charges above the **allowed amount**.

[2] Participants living in Connecticut, New Jersey, New York City or its surrounding area counties in New York have the POS **network**. Those living outside this area have the Empire Preferred Provider Organization ("PPO") **network**.

9. What is the allowed amount?

The **allowed amount** is not what the **doctor** charges you. It is the amount that the Plan will pay for a **covered service**, and it is generally a much lower amount than what the **doctor** charges you.

10. Are there any limits on the number of times I can see a doctor?

Generally there are no limits on the number of times you can see a **doctor**. However, there are some limits on certain types of services. For example, treatment for allergy care is covered up to 13 visits per year, 2 of which can be testing visits. (See pages 34–47 for all services with visit limits.)

11. What is my out-of-pocket cost for an emergency room visit?

$100 each for the first 2 emergency room visits per calendar year, $200 for each visit thereafter.

12. Is prior authorization required to receive services? Do I need to get permission before I can use some services?

Yes, prior authorization is required for the following services:

- Hi-tech Imaging (CT/PET scans, MRIs/MRAs and Nuclear Medicine tests),
- Other Imaging Services (bone density testing and echo stress tests),
- Hospital and inpatient surgery,
- Inpatient and intensive outpatient Mental/Behavioral Health,
- Inpatient and intensive outpatient Substance Abuse Disorder,
- Rehabilitation Services,
- Radiation Therapy,
- Skilled Nursing Care,
- Hospice Service (inpatient only),
- Durable Medical Equipment,
- Physical and Occupational Therapy,
- Air ambulance (non-emergency), and
- Ambulatory surgery (reconstructive and optical procedures).

When you use **participating providers,** the provider will get the prior authorization for you. If you use **non-participating providers**, it is your responsibility to get the prior authorization.

13. What is my out-of-pocket cost for an in-network hospital visit?

There is a $100 **co-payment** if you use an **in-network** hospital. In most cases, there will be no additional cost above the **co-payment** to you. However, talk to your **doctor** to make sure that your surgeon and other providers are also **in-network**. Because if they are not, you may be responsible for **deductibles** and **co-insurance** and you may be balance billed if the **out-of-network** provider's charges exceed the maximum **allowed amount**.

14. Do I have to file claims?

- ***No***. If you use a 5 Star Center or **in-network participating provider,** you do not have to file claims. The provider will do it for you.
- ***Yes.*** If you do not use a **participating provider**, you have to file the claims yourself.

15. Are all prescription drugs covered?

No. The Plan has a formulary or a list of covered drugs. This formulary includes generic and brand drugs.

16. What do I pay for prescription drugs that are on the Plan's formulary?

	Short-term Drugs at a Participating Pharmacy (up to a 30 day supply)	**Maintenance Drugs by Mail or at a CVS Pharmacy (up to a 90 day supply)**	**Non-Participating Pharmacy**
Generic Drugs	$10 **co-payment**	$20 **co-payment**	Covered up to what the Fund would pay a participating retail pharmacy less your **co-payment**.
Brand Drugs	$30 **co-payment**	$60 **co-payment**	Covered up to what the Fund would pay a participating retail pharmacy less your **co-payment**.

Your **doctor** can call CVS Caremark at 1-877-765-6294 for information on alternatives to drugs that you use that are not on the Plan's formulary.

17. What is the dental coverage?

- Preventive and diagnostic services, such as routine oral exams, cleanings, x-rays, topical fluoride applications and sealants,
- Basic therapeutic and restorative services, such as fillings and extractions,
- Major services, such as fixed bridgework, crowns, dentures and gum surgery, and
- Orthodontic services, such as diagnostic procedures and applications to realign teeth.

Dental benefits are subject to frequency limits and there is an annual maximum for adult dental care. (For additional details, see pages 60–69.)

18. How frequently can I get glasses and an eye exam?

Once every 24 months. Participants and dependent(s) under 19 are eligible for an eye exam once every 12 months.

19. Can I get disability benefits?

The Fund provides statutory short-term disability benefits to participants whose **employers** have opted to provide statutory short-term disability through the Fund. Contact the Fund Office at 1-800-551-3225 to determine if you are covered by the Fund. If you are not covered by the Fund, contact your **employer**.

20. What is my life insurance coverage?

$15,000.

There is no life insurance coverage for your dependent(s).

21. What if I have other health insurance?

If you, or your dependent(s), have other insurance, this Plan and your other plan will coordinate benefit payments. One plan will be primary and the other secondary. Generally, the plan that covers you, or your dependent, through work is the primary plan; for example, if your spouse has coverage at work, that plan will be primary for your spouse. The primary plan will pay first and the secondary plan may reimburse you for the remaining expenses up to the **allowed amount**. This process is known as Coordination of Benefits. (See pages 97–100 for more information.)

22. If I leave the industry or retire, how long can I stay on the health coverage?

Your coverage will continue at no cost for 30 days after your last day worked in **covered employment**. Prior to the expiration of the 30 days, you will be offered under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") the opportunity to purchase hospital, medical, mental health and substance abuse, prescription drug, dental and vision coverage for up to 17 more months.

23. What happens to my health coverage if I become disabled?

Your health coverage continues if you are collecting workers' compensation or short-term disability benefits for the period employer contributions are required, up to 26 weeks from the last date worked. (See page 16 and pages 75–76.)

24. What happens to my family's health coverage if I die?

If your family is enrolled/covered on the date of your death, their coverage will continue at no cost for 30 days. Prior to the expiration of the 30 days, your family will be offered the opportunity to continue coverage under COBRA for 35 more months by paying a monthly premium.

25. Who do I call if I have questions?

Call Member Services at 1-800-551-3225 Monday through Friday between the hours of 8:30 am to 5:00 pm, or visit the Welcome Center at 25 West 18th Street, New York, NY 10011, Monday through Friday between the hours of 8:30 am to 6:00 pm.

Eligibility and Participation

When You Are Eligible

Eligibility for benefits from the Plan depends upon the particular agreement that covers your work. Unless specified otherwise in your collective bargaining agreement or participation agreement, eligibility is as follows:

Your **employer** will be required to begin making contributions to the Plan on your behalf when you have completed 90 consecutive days of **covered employment** with the same **employer** working full time (as defined by your collective bargaining agreement or participation agreement), unless specified otherwise in your collective bargaining agreement or participation agreement. For this purpose, **covered employment** includes certain leaves of absence. Days of illness, pregnancy or injury count toward the 90-day waiting period. Except as otherwise provided on page 18 (see Special Rule for Seasonal Employees), when you have completed that 90-day period working for your **employer**, you and your eligible dependent(s) become eligible for the benefits described in this booklet on your 91st day of **covered employment**.

- This booklet describes the provisions of the Plan in effect as of January 1, 2015.

- In general, the Tri-State Preferred North Plan covers participants who work primarily in the Bronx.

Once you are eligible for benefits, you remain a participant as long as you are working in **covered employment**. You are considered to be in **covered employment**:

- during periods of active work,
- during paid vacation,
- while on jury duty,
- while collecting workers' compensation or short-term disability benefits for the period **employer** contributions are required, up to 26 weeks from the last day worked, and
- during periods of the Family and Medical Leave Act ("FMLA") leave. (See page 17, pages 104–105 and page 108 for more information.)

When You Are No Longer Eligible

Your eligibility for coverage under the Plan ends:

- at the end of the 30th day after you no longer regularly work in **covered employment**, subject to COBRA rights, (See page 17 and pages 106–111), including transfer to a job classification outside the jurisdiction of the collective bargaining agreement, layoff, leave of absence, or unpaid vacation. However, if your coverage is terminated due to delinquent employer contributions or because of a long expired collective bargaining agreement, you will receive a letter from the Fund Office notifying you of the date on which your coverage terminates,
- the earlier of when you have completed 26 weeks of workers' compensation or short-term disability, for a period during which employer contributions were required, or when you have exhausted your benefits under workers' compensation or short-term disability for a period during which employer contributions are required,
- on the date when your **employer** terminates its participation in the Plan, or
- on the date the Plan is terminated.

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Plan's hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision coverage. It does not include life insurance, Accidental Death & Dismemberment ("AD&D") and Short-Term Disability ("STD"). (See pages 16–17 and pages 106–111 for more information about COBRA.)

You may be entitled to take up to a 26-week leave of absence from your job under the Family and Medical Leave Act ("FMLA"). You may be able to continue health coverage during an FMLA leave. (See pages 16–17 and pages 104–105 for more information.)

If you are on active military duty, you have certain rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provided you enroll for continuation of health coverage. (See pages 105–106 for more information.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

In addition, the Board reserves the right, in its sole discretion, to terminate eligibility if your **employer** becomes seriously delinquent in its contributions to the Fund.

If You Come Back to Work

If your employment ends after your eligibility began and you return to **covered employment** with the same **contributing employer**, your participation in the Plan will recommence on the first day your **contributing employer** is required to recommence contributions to the Plan on your behalf under its collective bargaining agreement, unless otherwise required by law.

As long as you are eligible, your dependent(s) are eligible, provided they meet the definition of "dependent" under the Plan (see Dependent Eligibility on pages 18–23) and you have properly enrolled them.

Special Rule for Seasonal Employees

Because of different work schedules and different employer contribution schedules, the applicable collective bargaining agreement may provide special rules for the following group: employees covered under the New York Racing Association collective bargaining agreement. If you are a seasonal employee, consult your collective bargaining agreement or call the Fund Office for more information regarding your eligibility.

Dependent Eligibility

Eligible dependent(s) under the Plan are described on the following pages:

Dependency	Age Limitation	Requirements
Spouse	None	The person to whom you are legally married (if you are legally separated or divorced, your spouse is not covered). Spouses of the same gender are considered legally married if they were legally married under the laws of the jurisdiction in which the marriage occurred.
Children (except disabled children)	Until the end of the month in which the child turns 26.	The child is one of the following: • Your biological child, • Your adopted* child or one placed with you in anticipation of adoption, or • Your stepchild: this includes your spouse's biological or adopted child.
Children (disabled) over age 26	No age limit for coverage.	The child: • Is totally and permanently disabled, • Became disabled while, or before becoming, an eligible dependent, • Is not married, • Has the same principal address as the participant**, or as required under the terms of a "QMCSO"– see pages 111–112, and • Is dependent on the participant for over one-half of his or her annual support and is claimed as a dependent on your tax return**. You must apply for a disabled child's dependent coverage extension and provide proof of the child's total and permanent disability no later than 60 days after the date the child would have otherwise lost eligibility, and you must remain covered under the Plan. You will be notified of your adult disabled child's eligibility for continuing coverage. You must enroll your adult disabled child within 60 days of receiving confirmation of your adult child's eligibility. Failure to enroll at this time means your disabled adult child loses his or her special eligibility. If your child becomes eligible for extended coverage as a result of disability, you will be required to pay a monthly premium to cover part of the coverage cost. Contact Member Services.

Dependency	Age Limitation	Requirements
Children (dependent) – Your grandchild, niece or nephew ONLY if you are the legal guardian*** (if application for legal guardianship is pending, you must provide documentation that papers are filed and provide proof when legal process is complete)	Until the end of the month in which the child turns 26.	The child: • Is not married, • Has the same principal address as the participant**, or as required under the terms of a "QMCSO"—see pages 111–112, and • Is dependent on the participant for all of his or her annual support and maintenance and is claimed as a dependent on your tax return**.

Note that:

- A dependent must live in the United States, Canada or Mexico unless he or she is a United States citizen.
- A child is not considered a dependent under the Plan if he or she is in the military or similar forces of any country.

* Your adopted dependent child will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier (but not before you become eligible), if you enroll the child within 30 days after the earlier of placement or adoption. (See Your Notification Responsibility on pages 22–23.) 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. However, if a child is placed for adoption with you, but the adoption does not become final, that child's coverage will end as of the date you no longer have a legal obligation to support that child. If you adopt a newborn child, the child is covered from birth as long as you take custody immediately after the child is released from the hospital and you file an adoption petition with the appropriate state authorities within 30 days after the infant's birth. However, adopted newborns will not be covered from birth if one of the child's biological parents covers the newborn's initial hospital stay, a notice revoking the adoption has been filed or a biological parent revokes consent to the adoption.

** If you are legally separated or divorced, then your child may live with and/or be the tax dependent of the legally separated or divorced spouse. If you were never married to your child's other parent, then the child may live with the other parent but must be your tax dependent.

*** Legal guardian(ship) includes legal custodian(ship).

When Your Dependent(s) Are No Longer Eligible

Your dependent(s) remain eligible for as long as you remain eligible except for the following:

- Your *spouse's* eligibility ends 30 days after legal separation[3] or divorce.
- Your child's eligibility ends on the date your child no longer satisfies the requirements for a dependent child as described on pages 19–20.
- Eligibility of a spouse, and dependent children ends 30 days after your death.

How to Enroll

Coverage for dependent(s) under the Plan is not automatic.

If at the time you become eligible under the Plan you would like to enroll your eligible dependent(s), you must complete the appropriate form and submit it to the Fund within 30 days from the date you first became eligible for health benefits.

Please see Dependent Eligibility on pages 18–23 to determine whether your dependent(s) are eligible for enrollment. You will also be required to submit documents proving relationship status including a marriage certificate (for your spouse), birth certificates and, if applicable, proof of dependency (for your grandchildren, nieces and nephews). In most cases, your dependent's coverage will begin on the date he or she was first eligible. However, if you do not enroll your dependent(s) within 30 days from the date you first became eligible for health coverage under this Plan, your dependent's coverage will not begin until the date you notify the Fund. After your coverage under the Plan begins, if you have a change in family status (e.g., get married, adopt a child) or wish to change existing dependent coverage for any reason, you must complete the appropriate form. Special rules apply regarding the effective date of your new dependent's coverage. (Please see Your Notification Responsibility on pages 22–23 for further details.)

[3] Generally, a legal separation is any court order or agreement filed with the court under which the parties acknowledge they are living separately. Legal separation includes, but is not limited to, a divorce from bed and board, limited divorce, judicial separation, separate maintenance, inter-spousal agreement, marital property settlement agreement, and property settlement agreement.

Dependent claims for eligible expenses will be paid only after the Fund has received the appropriate form and supporting documentation. If your forms are not completely or accurately filled out, or if the Fund is missing requested documentation, any benefits payable will be delayed. The Fund may periodically require proof of continued eligibility for you, or your dependent. Failure to provide such information could result in a loss of coverage and a loss of the right to elect continuation of health coverage under COBRA.

Your Notification Responsibility

If, after your coverage under the Plan becomes effective, there is any change in your family status (e.g., marriage, legal separation, divorce, birth or adoption of a child), it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 30 days of marriage or birth or adoption of a child, coverage for your new spouse or child will begin as of the date of marriage or date of birth or adoption. If you do not notify the Fund within 30 days, coverage for your new spouse or child will begin as of the date you notify the Fund. No benefits will be paid until you provide the Fund with the necessary supporting documentation. Also, be sure to notify the Fund if your grandchild, niece or nephew no longer lives with you, marries or otherwise no longer satisfies the requirements for coverage as described on page 19–21.

If, after your coverage under the Plan becomes effective, your dependent(s) lose eligibility for Medicaid or Children's Health Insurance Program ("CHIP") or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan, it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 60 days of the loss of Medicaid/CHIP or of your dependent(s) becoming eligible for the state subsidy, coverage for your dependent(s) will begin as of the date your dependent(s) lost eligibility for Medicaid/CHIP or the date they became eligible for the subsidy. If you do not notify the Fund within 60 days, coverage for your dependent(s) will begin as of the date you notify the Fund. Failure to notify the Fund of your dependent(s)' loss of eligibility for Medicaid/CHIP or becoming eligible for the state subsidy could lead to a delay or denial in the payment of health benefits or the loss of a right to elect health continuation under COBRA.

Failure to notify the Fund of a change in family status could lead to a delay or denial in the payment of health benefits or the loss of a right to elect health continuation under COBRA. In addition, knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution.

What Benefits Are Provided

The Fund provides a comprehensive program of benefits, including hospital, medical, mental health and substance abuse, prescription drug, dental, vision, life insurance, accidental death and dismemberment and short-term disability benefits. Each of these benefits is described in the sections that follow.

Annual Out-Of-Pocket Maximum on In-Network Hospital, Medical, Mental Health, Substance Abuse and Pharmacy Benefits

*Annual out-of-pocket maximum on **in-network benefits**.* There is an annual out-of-pocket maximum on **in-network** hospital, medical, mental health, substance abuse and pharmacy benefits. The annual out-of-pocket maximum is the most you could pay during a calendar year coverage period for your share of the cost of **covered services**. Your individual annual out-of-pocket maximum is $6,600 and your family's annual out-of-pocket maximum is $13,200.*

The annual out-of-pocket maximum is divided between medical and prescription drug benefits as shown in the table below:

Annual In-Network Out-of Pocket Maximum	**You**	**Your Family**
Medical	$5,000	$10,000
Prescription Drug	$1,600	$ 3,200
Total	**$6,600**	**$13,200**

*Health and Human Services ("HHS") examines the limits annually and may increase them based on the premium adjustment percentage (an estimate of the average change in health insurance premiums). The Plan will change its out-of-pocket maximums each January 1st to match HHS' limits.

Expenses that apply toward the annual out-of-pocket maximum:

- **Co-payments,**
- **Deductibles,** and
- **Co-insurance.**

Expenses that do not count toward the annual out-of-pocket maximum. The following expenses are not applied toward the **in-network** annual out-of-pocket maximum:

- Premiums,
- Balance billing,
- Spending for non-covered services, and
- Penalties for failure to obtain pre-authorization.

Hospital, Medical, Mental Health and Substance Abuse Benefits

Effective April 1, 2015, the Plan provides hospital, medical, mental health and substance abuse benefits through Empire BlueCross BlueShield ("Empire"). The Plan offers the Empire BlueCross BlueShield Direct Point-of-Service ("POS") **network.**[4] This **network** includes over 85,000 **doctors** and other providers and almost 200 hospitals in the following three states:

- *New York:* 29 eastern counties – Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.
- *New Jersey:* all counties.
- *Connecticut:* all counties.

[4] If you are unable to locate an **in-network provider** in your area who can provide you with a service or supply that is covered under this Plan, you must call the number on the back of your I.D. Card to obtain authorization for **out-of-network** provider coverage. If you obtain authorization for services provided by an **out-of-network** provider, benefits for those services will be covered at the **in-network** benefit level.

Participants who reside outside of Connecticut, New Jersey or the New York counties identified on the preceding page will receive their hospital, medical, mental health and substance abuse benefits through the Empire Preferred Provider Organization ("PPO") **network**. The PPO allows participants and their dependent(s) to access **in-network benefits** through providers who participate in the local BlueCross BlueShield plan where the participant resides on the same terms as **in-network providers** under the POS. (All hospital and medical benefits described on the pages that follow are identical for the POS and PPO **networks**.)

Conditions for Hospital and Medical Expense Reimbursement

- Charges must be for **medically necessary** care. The Plan will pay benefits only for services, supplies and equipment that the Plan considers to be **medically necessary**.
- The Plan will pay benefits only up to the **allowed amount**.
- Charges must be incurred while the patient is covered. The Plan will not reimburse any expenses incurred by a person while the person is not covered under the Plan.

Empire ID Card. This card gives you access to thousands of **doctors**, surgeons, hospitals and other health care facilities in the **network**. It also gives you 24-hour phone access to a registered nurse who can help you with your health care decisions.

Nurses Healthline. This is round-the-clock information free to Empire members. When you call, you can either speak to a registered nurse or select from over 1,100 audio-taped messages in English or Spanish on a wide variety of topics. If you do not speak English or Spanish, interpreters are available through the AT&T language line. You may find it helpful to speak to a registered nurse when you need help assessing symptoms, deciding whether a trip to the emergency room is necessary or understanding a medical condition, procedure, prescription or diagnosis. You can reach the Nurses Healthline at 1-877-825-5276.

About Participating Providers and 5 Star Centers

Within Empire's POS **network,** there are participating **doctors** and specialists.

In addition to Empire's **network**, the 32BJ Health Fund has identified a **network** of 5 Star Centers. These centers have earned certification from the National Committee for Quality Assurance ("NCQA") and have agreed to work with the Fund to ensure that patients have access to comprehensive primary care.

When You Go In-Network

When you use an **in-network provider**, you will have low costs or no costs for **covered services**. In addition, there are no **deductibles** or **co-insurance** to pay, and no claims to file or track.

In an emergency, if you use out-of-network providers you may be responsible for deductibles and coinsurance and you may be balance billed if the out-of-network provider's charges exceed the allowed amount.

When you use a 5 Star Center, your expenses are covered at the highest level. You have no **co-payment** for **physician** and specialist office visits provided by the 5 Star Center.

When you use a **participating provider,** your expenses are still covered but it will cost you more. Your **co-payment** for participating **physicians** and specialists is $40 per office visit.

The **co-payment** for mental health or substance abuse professionals is $40 per office visit if you use a **participating provider** that is not at a 5 Star Center. If you use a provider at a 5 Star Center, your **co-payment** is $0.

In-network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a **network** provider. The **network** provider will assess your medical needs and advise you on appropriate care, as well as take care of any necessary tests, pre-certifications or hospital admissions. When you use a **doctor**, hospital or other provider **in-network**, the Plan generally pays 100% after the **co-payment** for most charges, including hospitalization. You will not have to satisfy a **deductible**.

You should always check with your **network** provider (or you can call Member Services at 1-800-551-3225) to be sure that any referrals to other **doctors** or for diagnostic tests are also with an **in-network provider**.

When You Go Out-of-Network

Care that is provided by an **out-of-network** provider is reimbursed at the lowest level. If you use **out-of-network** providers, you must first satisfy the annual **deductible**. After satisfying the annual **deductible**, you will be reimbursed at 50% of the **allowed amount**. The **allowed amount** is not what the **doctor** charges you. It is generally a much lower amount.

Amounts above the **allowed amount** are not eligible for reimbursement and are your responsibility to pay. This is in addition to any **deductibles** and required **co-insurance**. **Some services are not covered when you use an out-of-network provider. (See pages 34–47 and page 51 for additional information.)**

If you use an **out-of-network** provider, ask your provider if he or she will accept Empire's payment as payment in full (excluding your **deductible** or **co-insurance** requirements). While many providers will tell you that they take "32BJ" or "Empire" coverage, they may not accept Plan coverage as payment in full. Then they will bill you directly for charges that are over the Plan's **allowed amount**. This is called "balance billing." If your provider agrees to accept Empire's payment as payment in full, it is best to get their agreement in writing.

If your provider does not accept Empire's payment as payment in full, in addition to the 50% of the **allowed amount** you pay, you will then be responsible for the excess charges.

*Annual **deductible***. Your individual annual **deductible** is $500 and your family annual **deductible** is $1,000.

*Expenses that do not count toward the **deductible**:*

- **in-network co-payments**,
- charges that exceed the **allowed amount** for eligible **out-of-network** expenses,
- penalty amounts that you pay because you failed to pre-certify a hospital stay or meet any other similar pre-certification requirements, and
- charges excluded or limited by the Plan. (See pages 48–54.)

Co-insurance. Once the annual **deductible** is met, the Plan pays 50% of the **allowed amount** for eligible **out-of-network** expenses. You pay the remaining 50%, which is your **co-insurance**. You also pay any amounts over the **allowed amount**.

*Annual **co-insurance** maximum*. The Plan limits the **co-insurance** each patient has to pay in a given calendar year. It also limits the amount each family has to pay. Your annual **co-insurance** maximum is $1,250 and your family **co-insurance** maximum is $2,500. Any eligible expenses submitted for reimbursement after the annual **co-insurance** maximum is reached are paid at 100% of the **allowed amount**. You still have to pay any charge above the **allowed amount**.

*Expenses that do not count toward the **co-insurance** maximum*. The following expenses are not applied toward the **out-of-network** annual **co-insurance** maximum:

- **in-network co-payments**,
- **deductibles**,
- charges that exceed the **allowed amount** for eligible **out-of-network** expenses,
- amounts that you pay because you failed to pre-certify a hospital stay or meet any other similar pre-certification requirements, and
- charges excluded or limited by the Plan. (See pages 48–54.)

If you decide to stay with your choice of an **out-of-network** provider, then you should fully understand that your **out-of-network** claim will be paid as follows:

You must first satisfy the annual **deductible** before being reimbursed at 50% of the **allowed amount**.

Your Explanation of Benefits will show the maximum amount the provider can charge you. This will be reflected in the box labeled "Your Total Responsibility To Your Provider".

In addition to the 50% you pay, you are also responsible for the excess charges that the provider bills for. Below is an example of what **out-of network** care when using a non-participating provider can cost you:

- The non-participating surgeon's charge for total knee replacement surgery is **$5,000**. The **allowed amount** is **$1,310**. The amount above the **allowed amount** is **$3,690**. The Plan only takes into account the **allowed amount** when determining what it will pay.

The table below summarizes what you will pay and what the Fund will pay:

	You Pay	**Fund Pays**
Deductible	$500	$0
Co-insurance (50% of the **allowed amount**, less the **deductible**)	$405	$405
Amount above the **allowed amount**	$3,690	$0
Total	**$4,595**	**$405**

An **out-of-network** provider will cost you much more than an **in-network provider**.

Coverage When You Are Away from Home

When you are outside of the area covered by the POS **network** (see footnote 8 on page 127), you are covered for all **medically necessary** care on an **in-network** basis with a **co-payment** when using a local BlueCross BlueShield **participating provider**.

Benefit Maximums

There are no lifetime limits on hospital, medical, mental health and substance abuse benefits. However, there are limits on how much (and how often) the Plan will pay for certain services, even when they are covered. If there are limits on a particular service, those limits will be indicated under **covered services**. (See pages 34–47.)

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Pre-Certification

When you use a **network** provider, the provider will do the pre-certification for you. However it is your responsibility to verify that your provider has obtained the required pre-certification.

When you use an **out-of-network** provider, it is your responsibility to have the required services pre-certified. This means that you have to contact Empire's Medical Management Program as shown on pages 30–32, or make sure that your provider has done so. Failure to pre-certify will result in a financial penalty, which you will be responsible for paying.

Pre-Certification for Hospital, Medical, Mental Health and Substance Abuse

For hospital/medical services that require prior authorization, providers and members call 1-800-982-8089 24 hours a day, seven days a week.

For inpatient mental health/substance abuse that require prior authorization, providers and members call 1-855-531-6011 24 hours a day, seven days a week.

Type of Care	When You Must Call
Outpatient: • Air ambulance[9] (non-emergency) • MRI or MRA scans • PET, CAT and nuclear imaging studies • Bone density and echo stress tests • Physical and occupational therapy • Prosthetics/orthotics or durable medical equipment (rental or purchase) • Intensive outpatient services for behavioral or substance abuse • Radiation therapy	As soon as possible before you receive care.
• Surgical procedures (inpatient and ambulatory)	Two weeks before you receive surgery or as soon as care is scheduled.
Inpatient: • Scheduled hospital/mental health or substance abuse admissions • Hospice • Admissions to skilled nursing or rehabilitation facilities	Two weeks before you receive care or as soon as care is scheduled.
• Maternity admissions • **Emergency** admissions	Within 48 hours after delivery or admission.
• Maternity admissions lasting longer than two days (or four days for cesarean delivery) • Ongoing hospitalization	As soon as you know care is lasting longer than originally planned.

How pre-certification works. Empire's Medical Management Program will review the proposed care to certify the admission or number of visits (as applicable) and will approve or deny coverage for the procedure based on medical necessity. They will then send you a written statement of approval or denial within three business days after they have received all necessary information. In urgent care situations, Empire's Medical Management Program will make its decision within 72 hours after they have received all necessary information. (For more information, see pages 82–86.)

See footnote 9 on pages 127–128.

*If you do not pre-certify the care (except for pre-natal care) listed on the preceding page within the required time frames, benefit payments will be reduced by $250 for each admission, treatment or procedure. If the Plan determines that the admission or procedure was not **medically necessary**, no benefits are payable.*

Overview of Out-of-Pocket Expenses

The amount you are required to pay depends on where you receive your care and what kind of care you receive. In every case, you can minimize your out-of-pocket expense by using 5 Star Centers where they are available and by staying **in-network**.

You can avoid the $75 outpatient hospital **co-payment** by using free-standing medical facilities or **doctors'** offices for procedures like lab tests, physical therapy, diagnostic tests or minor surgical procedures.

There are no lifetime or annual dollar maximums for benefits. Some benefits have annual visit maximums. (See Schedule of Covered Services on pages 34–47.)

Type of care	**Out-of-Pocket Expense by Place of Service**		
Doctor Visits	**In-Network Co-Payment**		**Out-of-Network Expense**
	5 Star Center	**Participating Doctor/Provider**	**Non-Participating Providers**
Doctor's office	$0 per visit	$40 per visit	You pay the **deductible**, 50% of the **allowed amount** and any balance billing
Urgent care center	$0 per visit	$40 per visit	
Mental health or substance abuse visit	$0 per visit	$40 per visit	
Preventive care services	$0 per visit	$0 per visit	

Hospital & Facility Visits	**Participating Hospital or Facility Co-Payment**	**Non-Participating Hospital or Facility Expense**
Hospital emergency room	$100 per visit. After 2nd visit in a calendar year, $200.	You pay the **deductible**, 50% of the **allowed amount** and any balance billing**.**
Hi-tech radiology (CAT, MRI, MRA, PET, and nuclear studies)	$100 per scan	
Hospital inpatient	$100 per admission	
Hospital outpatient department	$75 per visit (except for maternity, chemotherapy, radiation therapy & intensive outpatient mental health and substance abuse services)*	

* No **co-payment** for maternity services. Outpatient radiation therapy and chemotherapy limited to one **co-payment** per calendar year. Intensive outpatient mental health or substance abuse services limited to one **co-payment** per episode of treatment.

Schedule of Covered Services

The following tables show different types of health care services, how they are covered **in-network** versus **out-of-network** and whether there are any limitations on their use:

In the Hospital[1] and Other Inpatient Treatment Centers *

Benefit	In-Network	Out-of-Network	Limitations
Semi-private room and board* (for obstetrical care, hospital stays are covered for at least 48 hours following normal delivery, or at least 96 hours following cesarean section)	Plan pays 100% after $100 **co-payment** per admission	Plan pays 50% of the **allowed amount** after the **deductible**	
In-hospital services of **doctors** and surgeons and other professionals	Plan pays 100%		
In-hospital anesthesia and oxygen			
In-hospital blood and blood transfusions			
Cardiac care unit ("CCU") and intensive care unit ("ICU")			
Inpatient chemotherapy and radiation therapy			
Inpatient kidney dialysis[3]			
Inpatient pre-surgical testing			
Special diet and nutritional services while in the hospital			
Inpatient lab and radiology services (including hi-tech radiology)			

* Pre-certification required for all inpatient admissions.

For definitions of various facilities and further details, see footnotes 1 and 3 on pages 124–126.

In the Hospital[1] and Other Inpatient Treatment Centers* (continued)

Benefit	In-Network	Out-of-Network	Limitations
Bariatric surgery*	Plan pays 100% after $100 **co-payment** per admission	Not Covered	Only covered at Blue Distinction Hospitals in the Empire **network.**
Transplant surgery* Lifetime travel maximum for a transplant	Plan pays 100% after $100 **co-payment** per admission $10,000 per transplant		Kidney and lung transplants are covered **in-network** only at any BlueCross BlueShield participating hospital. Other transplants are covered only at Blue Distinction Centers of Medical Excellence.[1] Call Member Services for a list of Blue Distinction Centers of Medical Excellence.
Skilled nursing care facility[4]*	Plan pays 100%	Not Covered	**In-network** only. Benefits are payable up to 60 days per year.
Hospice care facility[5]*	Plan pays 100%	Not Covered	**In-network** only.

* Pre-certification required for all inpatient admissions.

For definitions of various facilities and further details, see footnotes 1, 4 and 5 on pages 124–126.

Emergency Care

Benefit	In-Network	Out-of-Network	Limitations
Emergency room[8] ("ER") in a hospital	Plan pays 100% after $100 **co-payment** for 1st two visits; then $200 **co-payment** per visit		ER **co-payment** increases after the 2nd ER visit in a calendar year. Follow–up visits to the ER are not covered.
Urgent care center	Plan pays 100% after $40 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**	
Ambulance service[9]	Plan pays 100%		

See footnotes 8 and 9 on pages 127–128.

Outpatient Treatment Facilities

Benefit	In-Network	Out-of-Network	Limitations
Surgery[2] and care related to surgery (including operating and recovery rooms)*	Plan pays 100% after **co-payment** based on where service is provided: If in outpatient hospital setting – $75 **co-payment** If in freestanding surgical facility – $0 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**	When services are received in a hospital outpatient setting, there is a $75 **co-payment** per visit with the exception of chemotherapy and radiation therapy which have one $75 **co-payment** per calendar year**.**
Diagnostic procedures (like endoscopies) and lab and x-rays (not including hi-tech – see below)			
Radiation therapy*			
Chemotherapy			
Kidney dialysis[3]		Not Covered	**In-network** only.
Physical therapy*		Not Covered	**In-network** only. Limited to 30 visits per calendar year.
Hi-tech imaging (CAT, MRI, MRA, PET, nuclear imaging)*	Plan pays 100% after $100 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**	

* Pre-certification required.

See footnotes 2 and 3 on pages 125–126.

Care in the **Doctor's** Office

Benefit	In-Network	Out-of-Network	Limitations
Office visits (including surgery[2] in the office)	Plan pays 100% at 5 Star Centers. $0 **co-payment** at 5 Star Centers. Plan pays 100% after **co-payment** for office visits with **in-network providers**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)	Plan pays 50% of the **allowed amount** after the **deductible**	
Specialist visits			
Diabetes education and management [10]			
Allergy care			Limited to 13 visits per calendar year, two of which can be testing visits per calendar year for allergy care.
Hearing exams			When **medically necessary.**
Diagnostic procedures, lab and x-rays (not including hi-tech – see below)	Plan pays 100%		Lab work must be sent to an Empire participating lab, such as Quest or LabCorp.
Hi-tech imaging (CAT, MRI, MRA, PET, nuclear imaging)*	Plan pays 100% after $100 **co-payment**		
Chiropractic visits	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)		Limited to ten visits per calendar year.
Podiatric care, including routine foot care	Plan pays 100% at 5 Star Centers, otherwise there is a **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)		Excluding routine orthotics. **Medically necessary** orthotics limited to one pair per adult and two pairs per child per calendar year.
Acupuncture visits	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)	Not Covered	**In-network** only. Limited to 20 visits per calendar year.

*Pre-certification required.

See footnote 2 on page 125 and footnote 10 on page 128.

Home Health Care[6]

Benefit	In-Network	Out-of-Network	Limitations
Home health care visits[6]	Plan pays 100%	Not Covered	**In-network** only. Limited to 200 visits per calendar year.
Home infusion therapy[7]			**In-network** only.
Home kidney dialysis[3]			**In-network** only.
Home physical therapy			**In-network** only. Limited to 200 home care visits per calendar year, including home physical therapy.
Home hospice [5]			**In-network** only.

See footnote 3 on pages 125–126 and footnotes 5, 6 and 7 on pages 126–127.

Mental Health and Substance Abuse

Benefit	In-Network	Out-of-Network	Limitations
Mental health care:		Plan pays 50% of the **allowed amount** after the **deductible**	
Inpatient mental health*	Plan pays 100% after $100 **co-payment** per admission		
Physician office visits**	Plan pays 100% after $40 **co-payment**		
Outpatient hospital facility*	Plan pays 100% after a $75 **co-payment**		$75 **co-payment** per episode of intensive outpatient treatment in the hospital.
Substance abuse care:			
Inpatient substance abuse*	Plan pays 100% after $100 **co-payment** per admission		
Physician office visits**	Plan pays 100% after $40 **co-payment**		
Outpatient hospital facility*	Plan pays 100% after $75 **co-payment**		$75 **co-payment** per episode of intensive outpatient treatment in the hospital.

* Pre-certification required.

** There is no **co-payment** if provided at a 5 Star Center.

Preventive Medical Care[11]

Benefit	In-Network	Out-of Network	Limitations
Preventive health services[11], including annual physical exam and screening for colorectal, lung, skin cancer, hepatitis B and C, osteoporosis and obesity	Plan pays 100%. $0 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**	Covered preventive health services based on age, sex and health risk factors.
Well-woman care, which may include an annual well - woman exam and screening for cervical cancer, pregnancy related screenings, and reproductive health screenings			Annual exam and covered preventive health services based on age and health risk factors.
Well-child care[12] provides for regular checkups and preventive health services and immunizations identified in footnote 12 on pages 128–129			Well-child visits are subject to the frequency limits listed below and preventive health services based on age:

Well-child care visits are subject to the following frequency:

Age Range	Number of Visits
Newborn	1 exam at birth
0-1 years old	6 visits
1-4 years old	7 visits
5-11 years old	7 visits
12-17 years old	6 visits
18-19 years old	2 visits

See footnotes 11 and 12 on pages 128–129.

Preventive Medical Care[11] (continued)

Benefit	In-Network	Out-of Network	Limitations
Routine immunizations–all ages (includes travel immunizations)	Plan pays 100%. $0 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**	Immunizations based on age and health risk factors.
Mammograms *			Testing based on the patient's age and health risk factors.
Nutritional counseling			

* Coverage of mammograms regardless of age for covered persons with a past history of cancer or who have a first degree relative (parent, sibling, child) with a prior history of breast cancer, upon the recommendation of a **physician**.

See footnotes 11 and 12 on pages 128–129.

Family Planning Services

Benefit	In-Network	Out-of-Network	Limitations
Family planning office visits and counseling for contraceptive measures and devices (such as tubal ligation, IUD insertion and diaphragm fittings)	Plan pays 100%. $0 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**	
Vasectomy or tubal ligation (excludes reversals)	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)		
Abortion, includes elective and non-elective procedures			The type of facility where service is provided will determine **co-payment**.
Infertility treatment	Not Covered	Not Covered	No coverage for services upon the diagnosis of infertility.

Pregnancy and Maternity Care

Benefit	In-Network	Out-of Network	Limitations
Office visits for prenatal and postnatal care from a licensed **doctor** or certified nurse-midwife[13], including diagnostic procedures	Plan pays 100% after initial **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.) No **co-payment** for first postnatal visit.	Plan pays 50% of the **allowed amount** after the **deductible**	Prenatal **co-payment** limited to the **co-payment** for the first visit only for maternity care.
Newborn in-hospital nursery, and home care nursing services			
Obstetrical care* admission (in hospital or birthing center)	Plan pays 100% after $100 **co-payment** for admission	Plan pays 50% of the **allowed amount** after the **deductible.** No coverage for **out-of-network** birthing centers	**Out-of-network** birthing centers are not covered**.**
Home birth with a certified nurse- midwife[14]	Plan pays 100%	Plan pays 50% of the **allowed amount** after the **deductible.**	When the Plan authorizes the use of a non-participating nurse-midwife for home birth, then services are paid at the same rate as a participating obstetrician.
A home health care visit	Plan pays 100%		One (1) home health care visit within 24 hours of discharge if the mother leaves the hospital before the 48 or 96 hour period indicated under hospital benefits.
Circumcision of newborn males	Plan pays 100%		

* Pre-certification required.

See footnotes 13 and 14 on page 129.

Physical, Occupational, Speech or Vision Therapy (including rehabilitation)[15]

Benefit	In-Network	Out-of Network	Limitations
Inpatient services*	Plan pays 100% after $100 **co-payment** per admission	Plan pays 50% of the **allowed amount** after the **deductible**	Covered for up to 30 days of inpatient physical therapy per calendar year (**in-network** and **out-of-network** combined).
Outpatient services* Outpatient facility or **doctor's** office	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)	Not Covered	**In-network** only. Benefits are payable for up to 30 visits per calendar year for physical therapy. An additional 30 visits per calendar year combined for occupational, speech and vision therapy.
Services in the home	Plan pays 100%		**In-network** only. Limited to 200 visits per calendar year for all home visits, including home physical therapy visits.

* Pre-certification required.

See footnote 15 on page 129.

Durable Medical Equipment and Supplies[16]

Benefit	In-Network	Out-of-Network	Limitations
Durable medical equipment* (such as wheelchairs, nebulizers, oxygen and hospital beds)	Plan pays 100%	Not Covered	**In-network** benefit only.
Prosthetics/ orthotics*	Plan pays 100%	Not Covered	Orthotics are covered only for non-routine foot orthotics – limited to one pair per adult and two pairs per child in a calendar year.
Medical and diabetic supplies (such as catheters and syringes)	Plan pays 100%	Not Covered	**In-network** only benefit
Wigs	Plan pays 100%	Plan pays 50% of the **allowed amount** after the **deductible**	Only covered following chemo or radiation therapy.
Nutritional supplements[17] that require a prescription (such as formulas and modified solid food products)	Plan pays 100%	Plan pays 50% of the **allowed amount** after the **deductible**	
Hearing aids	Plan pays 100% for two hearing aids per lifetime	Not Covered	Lifetime benefit limitation. Covered only with a participating hearing aid provider.

* Pre-certification required.

See footnotes 16 and 17 on pages 129–130.

Dental Care*

Benefit	In-Network	Out-of-Network	Limitations
Surgical removal of impacted wisdom teeth only	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on pages 32–33.)	Plan pays 50% of the **allowed amount** after the **deductible**	
Repair to natural teeth only within 12 months of injury to sound natural teeth			

*Dental care is also covered under the Plan's dental benefits described on pages 60–69 of this SPD.

Excluded Hospital, Medical, Mental Health and Substance Abuse Expenses

The following expenses are not covered under the hospital, medical, mental health and substance abuse coverage. However, some of these expenses are covered under your prescription drug, vision or dental coverages.

Check the other sections of this booklet to see if an expense not paid under hospital/medical is covered elsewhere under the Plan.

- expenses incurred before the patient's coverage began or after the patient's coverage ended
- treatment that is not **medically necessary**
- cosmetic treatment[18]
- technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are experimental, investigative, obsolete or ineffective.[19] Also excluded is any hospitalization in connection with experimental or investigational treatments
- expenses for the treatment of infertility
- assisted reproductive technologies including, but not limited to, in-vitro fertilization, artificial insemination, gamete and zygote intrafallopian tube transfer and intracytoplasmic sperm injection
- surgery and/or non-surgical treatment for gender change
- reversal of sterilization
- travel expenses, except as specified
- psychological testing for educational purposes for children or adults
- common first-aid supplies such as adhesive tape, gauze, antiseptics, ace bandages, and surgical appliances that are stock items, such as braces, elastic supports, semi-rigid cervical collars or surgical shoes
- expenses for acupressure, prayer, religious healing including services, and naturopathic, naprapathic, or homeopathic services or supplies
- expenses for memberships in or visits to health clubs, exercise programs, gymnasiums or other physical fitness facilities
- commercial weight loss programs, e.g., Weight Watchers and Jenny Craig
- operating room fees for surgery, surgical trays and sterile packs done in a non–state-licensed facility including the **doctor's** office

See footnotes 18 and 19 on pages 130–131.

- routine orthotics for foot care (including dispensing of surgical shoe(s) and pre- and post-operative X-rays) pertaining to routine foot care
- routine hearing exams for adults
- treatment for services for mental retardation
- formal psychological evaluations and fitness for duty opinions
- long-term hospitalization for residential care
- training or educational therapy for reading or learning disabilities
- testing, screening or treatment for learning disorders, expressive language disorders, mathematics disorders, phonological disorders and communication disorders
- treatment for conditions not listed as mental disorders in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*
- behavioral health treatment rendered by Licensed Mental Health Counselors, Licensed Masters Social Workers (who are non-independent social workers who work under the supervision of another licensed professional), Licensed Marriage and Family Therapists and Licensed Psychoanalysts
- psychological testing (except as conducted by a Licensed Psychologist for assistance in treatment planning, including medication management and diagnostic clarification) and specifically excluding all educational, academic and achievement tests
- **ambulette**, except as provided in footnote 6 on page 127
- private-duty nursing
- the following specific preventive care services:
  - screening tests done at your place of work at no cost to you
  - free screening services offered by a government health department
  - tests done by a mobile screening unit, unless a **doctor** not affiliated with the mobile unit prescribes the tests
- the following specific **emergency** services:
  - use of the emergency room to treat routine ailments because you have no regular **doctor** or because it is late at night (and the need for treatment does not meet the Plan's definition of **emergency.)** (See page 122.)
  - use of the emergency room for follow-up visits

- the following specific maternity care services:
  - days in hospital that are not **medically necessary** (beyond the 48-hour/96-hour stays the Fund is required by law to cover)
  - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The additional cost does not count toward your **deductible** or **co-insurance**.)
  - **out-of-network** birthing center facilities
  - private-duty nursing
  - services of a doula
- the following specific inpatient hospital care expenses:
  - private duty nursing
  - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The additional cost does not count toward your **deductible** or **co-insurance**.)
  - diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
  - any part of a hospital stay that is primarily custodial
  - elective cosmetic surgery[18] or any related hospital expenses or treatment of any related complications
  - hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility
  - bariatric surgery at a facility that is not a Blue Distinction hospital within the Empire **network**
- the following specific outpatient hospital care expenses:
  - routine medical care including, but not limited to, inoculation, vaccination, drug administration or injection, excluding chemotherapy
  - collection or storage of your own blood, blood products or semen

See footnote 18 on page 130.

- all excluded **out-of-network** services

  The following **out-of-network** services and/or expenses are excluded from coverage under the Plan. **No benefits will be paid by the Plan for the following out-of-network services**:
  - kidney dialysis
  - bariatric surgery performed at a hospital that is not a Blue Distinction Center of Medical Excellence facility
  - transplant surgery for bone marrow, liver, heart and pancreas performed at a hospital that is not a Blue Distinction Center of Medical Excellence facility
  - transplant surgery for a lung transplant performed at a non-participating BlueCross BlueShield hospital
  - skilled nursing facility
  - home health care
  - hospice care facility
  - home infusion therapy
  - birthing centers
  - outpatient physical, occupational speech, and vision therapy
  - durable medical equipment
  - prosthetics/orthotics
  - medical supplies
  - hearing aids
- the following specific equipment:
  - air conditioners or purifiers
  - humidifiers or dehumidifiers
  - exercise equipment
  - swimming pools
- skilled nursing facility care that primarily:
  - gives assistance with daily living activities
  - is for rest or for the aged
  - is convalescent care
  - is sanitarium-type care
  - is a rest cure

- the following specific home health care services:
  - custodial services, including bathing, feeding, changing or other services that do not require skilled care
- the following specific physical, occupational, speech or vision therapy services:
  - therapy to maintain or prevent deterioration of the patient's current physical abilities
  - treatment for developmental delay, including speech therapy
- the following specific vision care services:
  - expenses for surgical correction of refractive error or refractive keratoplasty procedures including, but not limited to, radial keratotomy ("RK"), photo-refractive keratotomy ("PRK") and laser in situ keratomileusis 21 ("LASIK") and its variants
  - eyeglasses, contact lenses and the examination for their fitting except following cataract surgery. However, see Vision Care Benefits on pages 70–71, to find out how eyeglasses and contact lenses may be covered under the vision program
  - routine vision care (See Vision Care Benefits on pages 70–71 for coverage information.)
- the following services that may be covered elsewhere under the Plan:
  - dental treatment, except surgical removal of impacted teeth or treatment of sound natural teeth injured by accident if treated *within 12 months* of the injury; however, see Dental Benefits on pages 60–69
  - all prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, vitamin therapy, appetite suppressants, or any other type of medication, unless specifically indicated. However, see Prescription Drug Benefits on pages 54–59, to find out how prescription drug expenses may be covered.
  - false teeth (not covered under hospital/medical, but may be covered under dental.) (See Dental Benefits on pages 60–69.)
- the following miscellaneous health care services and expenses:
  - services performed in nursing or convalescent homes, institutions primarily for rest or for the aged, rehabilitation facilities (except for physical therapy), spas, sanitariums, or infirmaries at schools, colleges or camps
  - injury or sickness that arises out of any occupation or employment for wage or profit for which there is Workers' Compensation or occupational disease law coverage (for information about subrogation of benefits, see pages 101–104)
  - injury or sickness that arises out of any act of war (declared or undeclared) or military service of any country
  - injury or sickness that arises out of a criminal act (other than domestic violence) by the covered person, or an intentionally self-inflicted injury that is not the result of mental illness
  - expenses for services or supplies for which a covered person receives payment or reimbursement from casualty insurance or as a result of legal action, or expenses for which the covered person has already been reimbursed by another party who was responsible because of negligence or other tort or wrongful act of that party (for information about subrogation of benefits, see pages 101–104)
  - expenses reimbursable under the "no-fault" provisions of a state law
  - services covered under government programs, except under Medicare, Medicaid or where otherwise noted
  - any hospital or **physician** care received outside of the U.S. that is not **emergency** care
  - government hospital services, except specific services covered under a special agreement between Empire and a governmental hospital or services in United States Veterans' Administration or Department of Defense hospitals for conditions not related to military service
  - treatment or care for temporomandibular disorder or temporomandibular joint disorder ("TMJ") syndrome
  - services such as laboratory, X–ray and imaging, and pharmacy services from a facility in which the referring **doctor** or his or her immediate family member has a financial interest or relationship
  - services given by an unlicensed provider or performed outside the scope of the provider's license
  - charges for services a relative provides
  - charges that exceed the maximum **allowed amount** or visits that exceed the annual maximum for that service or supply
  - services performed at home, except for those services specifically noted in this booklet as covered either at home or in an **emergency**
  - services usually given without charge, even if charges are billed

– services performed by hospital or institutional staff that are billed separately from other hospital or institutional services, except as otherwise specified in this booklet

Prescription Drug Benefits

Your prescription drug benefits are administered by CVS Caremark. The list of prescription drugs that are covered by your Plan is known as a "formulary". Your Plan's formulary is mandatory generic and includes a wide selection of generic and brand-name medications. Certain drugs require prior approval and/or step therapy. Your **physician** can call CVS Caremark at 1-800-294-5979 for additional information.

The table below shows your **co-payments** for short-term and maintenance generic and brand drugs:

	Short-term Drugs at a Participating Pharmacy (up to a 30 day supply)	**Maintenance Drugs by Mail or at a CVS Pharmacy (up to a 90 day supply)**	**Non-Participating Pharmacy**
Generic Drugs	$10 **co-payment**	$20 **co-payment**	Covered up to what the Fund would pay a participating retail pharmacy less your **co-payment**.
Brand Drugs	$30 **co-payment**	$60 **co-payment**	Covered up to what the Fund would pay a participating retail pharmacy less your **co-payment**.

If the cost of the drug is less than the **co-payment**, you pay the cost of the drug.

If your **doctor** prescribes a formulary brand-name drug and initials the "Dispense As Written" ("DAW") box when an "A"-rated generic equivalent drug is available, you will have a $30 **co-payment** and you will have to pay the difference in cost between the brand-name drug and the generic drug. Brand-name drugs can be very costly so always ask your **doctor** to prescribe generic drugs when possible.

Note: You can have your prescription filled at a non-participating pharmacy, but you will have to pay the full cost and then file a claim with CVS Caremark to be reimbursed up to the amount CVS Caremark would have paid a participating pharmacy (minus your **co-payment**). Contact CVS Caremark over the phone or on-line to obtain the necessary claim form if you have your prescription filled at a non-participating pharmacy. (See inside back cover for the phone number and the website for CVS Caremark.)

Specialty Drugs

Your pharmacy benefits also cover specialty drugs that are on the CVS Caremark formulary. The **co-payment** for specialty drugs is the same as described in the table on page 54. In order to be covered for a formulary specialty drug, you must fill your specialty drug prescription at a CVS retail pharmacy or through the CVS Caremark Specialty Pharmacy. There is no coverage for formulary specialty drugs unless they are filled using one of these two methods.

Chronic Care Prescription Drug Discount Program

Members and their dependent(s) with diabetes, asthma, heart disease, chronic obstructive pulmonary disease ("COPD"), hypertension, stroke and peripheral artery disease ("PAD") who receive all their health care services* for their chronic care problem at one of the 5 Star Centers can receive prescription drugs, whether generic or brand, for a **co-payment** of $5 at any participating retail pharmacy for a 30-day supply or $10 at either CVS Caremark mail service or at a CVS pharmacy for a 90-day supply. For more information, or to see if you are eligible, call Member Services at 1-877-299-1636 or email us at 5StarCenterTeam@32bjfunds.com.

*This requirement does not apply to **emergency** or urgent care services or services that are not available at the 5 Star Center.

There are several ways to get your prescriptions filled:

For Short-term Medications–At the Pharmacy

When you need to take a prescription for a period of no more than 60 days, you can have your prescription filled at a retail pharmacy. Just go to a

participating pharmacy with your prescription and your CVS Caremark ID Card. All prescriptions filled at a participating pharmacy provide you with up to a 30-day supply and one refill of up to a 30-day supply.

For Maintenance Medications

If you need to take a prescription for a long time, then there are two ways you can fill your prescription:

1. Through the Maintenance Choice Program at any CVS pharmacy, or
2. Through the CVS Caremark's Mail Service Program.

You save money by using either the Maintenance Choice Program or the CVS Caremark's Mail Service Program since you receive a 3-month supply for the equivalent of 2 months of **co-payment**.

Using either the Maintenance Choice Program or the CVS Caremark Mail Service Program is mandatory for those who take maintenance drugs (medication taken on a regular basis for chronic conditions, such as high blood pressure, diabetes or high cholesterol). You can use whichever program works best for you.

Through the Maintenance Choice Program

You can get your maintenance medications at any CVS Pharmacy. Simply present your prescription for a 90-day supply of the medication, pay your **co-payment** for your medication ($20 for generic medications and $60 for brand name medications) and get your prescription right from the CVS Pharmacy. All refills can also be filled at the CVS Pharmacy.

Through CVS Caremark Mail Service Program

You can use the CVS Caremark mail order service by following these steps:

- For your first mail service order, fill in the patient profile sections of the Mail Order Pharmacy Order Form, which you can get from Member Services or by calling CVS Caremark at 1-877-765-6294. Be sure to complete as much of the information requested as possible. You must provide your unique CVS Caremark identification number, name of the person or persons for whom you are sending prescriptions and the address to whom the medication should be sent. Provide any allergy or history information so that the pharmacist will be aware of any potential drug conflict.
- Complete the Mail Order Pharmacy Order Form for each new prescription.
- Enclose your maintenance drug prescription, the Mail Order Pharmacy Order Form and your payment in the pre-addressed mail service envelope. You must make the necessary **co-payment** for your mail order or your prescription may not be filled. Your medications are delivered to you at home postage-paid by United Parcel Service or by U.S. mail. Allow 10 to 14 days after the prescription is filled for delivery of your medicine.
- A new order form and envelope will be sent to you with each delivery. These forms are also available from Member Services or CVS Caremark.

If you are concerned about not receiving the drugs in time, ask your **doctor** to write two prescriptions – one for a 30-day supply to fill right away at your local retail pharmacy and a second for a 90-day supply to send to the mail order pharmacy for a long-term supply.

You can order refills by phone (call CVS Caremark customer service toll-free at 1-877-765-6294) or from their website (www.Caremark.com). Have your prescription number and credit card ready when you call or log on.

Refills are not shipped automatically. If you have remaining refills on your original prescription, request your CVS Caremark refill three weeks before you need it to avoid running out of medication. You should receive your refill within a week.

Prescriptions for medicines not available through the mail (such as narcotics) will be returned to you. These prescriptions can be filled at your local CVS Caremark participating pharmacy for up to a 30-day supply.

Please note that certain prescription drugs, whether filled in the participating pharmacy or through the mail service, require prior authorization. Your pharmacist can tell you if the prescription drug order

you need to have filled requires prior authorization. Contact CVS Caremark at 1-877-765-6294 before having the prescription filled to ensure that you will receive regular reimbursement for the prescription that you have been given. If you have a prescription filled for a drug that is on the list of those requiring prior authorization, and you fail to contact CVS Caremark before having the prescription filled, you may be fully responsible for the cost of the prescription drug.

Through CVS Caremark Specialty Pharmacy Program

If you choose not to fill your specialty drug at a CVS retail pharmacy, you must use the CVS Caremark Specialty Pharmacy Program.

To use the CVS Caremark Specialty Pharmacy Program, you must call 1-800-237-2767. A CVS Caremark service representative will assist you in completing the specialty drug registration process.

Note: If your specialty medication is perishable, then the Specialty Pharmacy will send your 90 day prescription order in three separate deliveries of 30 day fills over the course of the 90 days. With each 30 day fill that the Specialty Pharmacy sends, it will charge you 1/3 of the **co-payment** required.

Frequency Limitation

All prescriptions for proton pump inhibitors ("PPIs"), such as Nexium or Omeprezole, will be filled for up to a 90-day supply in a 180 day period.

Eligible Drugs

The following are covered under the Plan:

- Federal legend prescription drugs,
- drugs requiring a prescription under the applicable state law,
- insulin, insulin syringes and needles,
- diabetic test strips,
- all FDA approved types of contraceptives, including oral and sub-dermal contraceptive prescriptions, contraceptive injections and miscellaneous contraceptive devices, with no **co-payment** required,
- prescription vitamins for infants to 12 months, and
- prenatal vitamins, with no **co-payment** required, for up to 15 months.

Excluded Drugs

The following are not covered under the Plan:

- over-the-counter drugs and vitamins (however, certain vitamins are covered for prenatal care – see above for information),
- prescription drugs that require prior authorization and for which you have not received prior authorization,
- drugs used in clinical trials or experimental studies except as otherwise required by law,
- drugs used for infertility treatment or egg donation,
- drugs prescribed for cosmetic purposes (See footnote 18 on page 130 for more information.),
- drugs used for weight loss unless you meet the Plan's medical criteria,
- non-formulary drugs, unless your **doctor** can prove (i.e., clinical documentation; patient's drug therapy history) to CVS Caremark's satisfaction that the non-formulary drug is necessary (non-formulary drugs are drugs that are not on the Plan's list of approved drugs and medicines),
- therapeutic devices or appliances, support garments and other non-medical substances, and
- prescriptions that an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state or Federal program.

Dental Benefits

How the Plan Works

The Plan provides coverage for necessary dental care received through:

- a participating dentist, or
- a non-participating dental provider.

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

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

Covered services are listed in the Schedule of Covered Dental Services (see pages 63–66 in this booklet), subject to frequency limitations that are stated in that Schedule. The Plan pays no benefits for procedures that are not in that Schedule, but may provide an alternate benefit if approved by the Fund. Whether you have to pay for those services and, if so, how much, depends on whether you choose to receive your dental care from a participating dental provider or from a non-participating dentist.

Participating Dental Providers

The Plan's dental benefits include a "participating dental provider" feature. Dentists who are in the Plan's participating dental provider **network** have agreed to accept the amount that the Plan pays as payment in full for their dental services. If you choose to receive your care from a participating dental provider, you will not have to pay anything for covered dental care you receive, except for osseous surgery, for which you will have to make a $125 **co-payment** for each quadrant, and periodontal scaling and root planing, for which there is a 100% **co-payment**.

Non-Participating Dentists

The Plan will pay for dental work performed by any properly accredited dentist, but the Plan will pay no more than the amount listed on its Schedule of Allowed Amounts. (Contact Member Services for a copy of the Schedule of Allowed Amounts.) If the dentist charges more than those amounts for your dental care, you will be responsible to pay the difference between what the dentist charges and what the Plan pays. Be sure to ask the dentist before you start treatment what the charges will be, so that you will know what your out-of-pocket expenses may be.

The Fund will pay the lesser of the dentist's actual charge for a covered dental service or the **allowed amount** for that procedure, as indicated in the Schedule of Allowed Amounts.

Prior Approval

When using a 32BJ participating dental provider ("PDP"), if any prior approvals are required for treatment, your PDP will secure this approval for you. Prior approval for dental services and treatment plans is required when you use a PDP. If your PDP fails to obtain the necessary prior approval, and your claim is denied due to this failure, you will not be responsible.

Prior approval for dental services or treatment plans is not required when you use a non-participating dental provider. However, if you use a non-participating dental provider, obtaining prior approval for dental services and treatment plans is recommended, so you will know in advance whether your services will be covered and the amount you will owe, if any. A non-participating dental provider or the member can request prior approval for dental services and treatment plans from:

Administrative Services Only, Inc. ("ASO, Inc.")
Building Service 32BJ Health Fund
Dedicated Unit
P.O. Box 9011
Lynbrook, NY 11563-9011
516-394-9485 (for members)
516-394-9486 (for providers)

If a non-participating dental provider or the member submits a request for prior approval for dental services or a treatment plan, and it is approved, it is valid for up to one year. Changes to an approved treatment plan are not covered under the original approval. If you would like to know whether changes are covered, a new prior approval must be submitted.

What Dental Services Are Covered

The Plan covers a wide range of dental services, including:

- Preventive and diagnostic services, such as routine oral exams, cleanings, X-rays, topical fluoride applications, space maintainers and sealants,
- Basic therapeutic services, such as extractions and oral surgery, intravenous conscious sedation when **medically necessary** for oral surgery, gum treatment, gum surgery, fillings and root canal therapy,
- Major services, such as fixed bridgework, crowns and dentures, and
- Orthodontic services, such as diagnostic procedures and appliances to realign teeth. There is a separate lifetime maximum on routine orthodontic services of $2,500 for one course of treatment. Initial diagnosis is covered separately.

See the Schedule of Covered Dental Services on pages 63–66 for details.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services as shown on pages 63–66.

Annual Maximum

An annual maximum benefit of $2,500 per person on dental care. There is no annual maximum for participants and dependents(s) under 19 years of age.

Schedule of Covered Dental Services

Procedure	Limits
Diagnostic	
Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused)	Once every six months
X-rays:	
• full mouth, complete series, including bitewings or panoramic film	Once in any 36 consecutive months
• bitewings, back teeth	Four films every six months
• periapicals, single tooth	As necessary up to yearly combined maximum of $28
• occlusal film	As necessary up to yearly combined maximum of $28
• cephalometric film (orthodontic coverage only)	Once in a lifetime
Preventive	
Dental prophylaxis (cleaning, scaling and polishing)	Once every six months
Topical fluoride treatment	Once in any calendar year for patients under age 16
Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)	Once per tooth in any 24 consecutive months for patients under age 16
Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)	Once per tooth for patients under age 16
Simple Restorative	
Amalgam (metal) fillings	Once per tooth surface in any 24 consecutive months
Resin (composite, tooth-colored) fillings	Once per tooth surface in any 24 consecutive months

Schedule of Covered Dental Services (continued)

Procedure	Limits
Major Restorative	
Recementation of crown	Once per tooth in any calendar year
Prefabricated stainless steel/resin crown (deciduous teeth only)	Once per tooth in any 60 consecutive months
Crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture	Once per tooth in any 60 consecutive months
Endodontics	
Root canal therapy	Once per tooth in a lifetime
Retreatment of root canal	Once per tooth in a lifetime
Apicoectomy (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment)	Once per tooth in a lifetime
Pulpotomy	Once per tooth in a lifetime
Periodontics	
Gingivectomy or gingivoplasty	Once per quadrant in a lifetime
Osseous surgery (prior approval is required with a full-mouth series of X-rays and periodontal charting). In all cases, a participating periodontal specialist may require you to make a **co-payment** of $125 per quadrant.	Once per quadrant in a lifetime
Periodontal scaling and root planing	100% **co-payment**
Periodontal maintenance (covered only if the Plan also covered periodontal surgery and the maintenance procedure is performed by a periodontist)	Twice in any calendar year

Schedule of Covered Dental Services (continued)

Procedure	Limits
Removable Prosthodontics	
Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care	One denture per arch in any 60 consecutive months
Denture rebase or reline procedures, including six months of routine post-delivery care	Once per appliance in any 36 consecutive months
Interim maxillary and mandibular partial denture (anterior teeth only); no other temporary or transitional denture is covered by the Dental Plan	Once per appliance in any 60 consecutive months
Fixed Prosthodontics	
Fixed partial dentures and individual crowns	Once per tooth in any 60 consecutive months
Prefabricated post and core procedures related to fixed partial denture (X-ray showing completed endodontic procedure is required)	Once per tooth in any 60 consecutive months
Simple Extractions	
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Once per tooth
Oral and Maxillofacial Surgery	
Removal of impacted tooth	Once per tooth in a lifetime
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)	Once per quadrant in a lifetime
Frenulectomy	Once per arch in a lifetime
Removal of exostosis (removal of overgrowth of bone)	Once per site in a lifetime
Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm and incision and drainage of an intraoral or extraoral abscess.	

Schedule of Covered Dental Services (continued)

Procedure	Limits
Emergency Treatment	
Palliative treatment to alleviate immediate discomfort (minor procedure only)	Twice in any calendar year
Repairs	
Temporary crown (fractured tooth)	Once per tooth in a lifetime
Crown repair	Once per tooth in any 36 consecutive months
Overcrown	Once per tooth in any 60 consecutive months
Repairs to complete or partial dentures	Once per appliance in any calendar year
Recement fixed or partial dentures	Once per appliance in any calendar year
Additions to partial dentures	Two procedures in a calendar year
Orthodontics	One course of treatment in a lifetime, up to $2,500 Initial diagnosis is separate coverage
Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association. A "course of treatment" is defined as 30 consecutive months of active orthodontic treatment, including braces, monthly visits and retainers.	
Miscellaneous	
Occlusal guard	One appliance in any 60 consecutive months

Alternate Benefit for Dental Coverage

There is often more than one way to treat a given dental problem. For example, a tooth could be repaired with an amalgam filling, a resin composite or a crown. If this is the case, the Plan will generally limit benefits to the least expensive method of treatment that is appropriate and that meets acceptable dental standards. For example, if your tooth can be filled with amalgam and you, or your dentist, decide to use a crown instead, the Plan pays benefits based on the amalgam. You will have to pay the difference.

What Is Not Covered

The Plan's dental coverage will not reimburse or make payments for the following:

- any services performed before a patient becomes eligible for benefits or after a patient's eligibility terminates, even if a treatment plan has been approved
- reimbursement for any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services
- charges in excess of the **allowed amounts,** contact Member Services for the Schedule of Allowed Amounts for each covered service or the annual or lifetime amount
- treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accident
- services or supplies that the Plan determines are experimental or investigative in nature
- services or treatments that the Plan determines do not have a reasonably favorable prognosis
- any treatment performed principally for cosmetic reasons including, but not limited to, laminate, veneers and tooth bleaching
- special techniques, including precision dentures, overdenture, characterization or personalization of crowns, dentures, fillings or any other service. This includes, but is not limited to, precision attachments and stress-breakers. Full or partial dentures that require special techniques and time due to special problems, such as loss of supporting bone structure, are also excluded

- any procedures, appliances or restorations that alter the "bite", or the way the teeth meet (also referred to as occlusion and vertical dimension), and/or restore or maintain the bite, except as provided under orthodontic benefits. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for misalignment of teeth
- any procedures involving full-mouth reconstruction, or any services related to dental implants, including any surgical implant with a prosthetic device attached to it
- diagnosis and/or treatment of jaw joint problems, including temporomandibular joint disorder ("TMJ") syndrome, craniomandibular disorders or other conditions of the joint linking the jaw bone and skull or the complex of muscles, nerves and other tissue related to that joint
- double or multiple abutments
- treatment for self inflicted injury or illness
- treatment to correct harmful habits including, but not limited to, smoking and myofunctional therapy (but smoking cessation may be covered under medical as a preventive service or under the prescription drug program)
- habit-breaking appliances, except under the orthodontics benefit
- services for plaque-control programs, oral hygiene instruction and dietary counseling
- services related to the replacement or repair of appliances or devices, including:
  - duplicate dentures, appliances or devices
  - the replacement of lost, missing or stolen dentures and appliances less than five years from the date of insertion or the payment date
  - replacement of existing dentures, bridges or appliances that can be made useable according to dental standards
  - adjustments to a prosthetic device within the first six months of its placement that were not included in the device's original price
  - replacement or repair of orthodontic appliances

- drugs or medications used or dispensed in the dentist's office (any prescriptions that are required may be covered by the Plan's prescription drug benefits. (See pages 54–59.)
- charges for novocaine, xylocaine, or any similar local anesthetic when the charge is made separately from a covered dental expense
- additional fees charged by a dentist for hospital treatment
- services for which a participant has contractual rights to recover cost, whether a claim is asserted or not, under Workers' Compensation, or automobile, medical, personal injury protection, homeowners or other no-fault insurance
- treatment of conditions caused by war or any act of war, whether declared or undeclared, or a condition contracted or an accident occurring while on full-time active duty in the armed forces of any country or combination of countries
- any portion of the charges for which benefits are payable under any other part of the Plan
- if a participant transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for the same procedure, the Plan will not pay benefits greater than what it would have paid if the service had been rendered by one dentist
- transportation to or from treatment
- expenses incurred for broken appointments
- fees for completing reports or for providing records
- any procedures not listed under the Schedule of Covered Dental Services

Coordination of Dental Benefits

If you have dental coverage through another carrier, which serves as your primary dental insurer, prior approval is not required if you got this approval through your primary dental insurer. See pages 60–62 for the rules that determine which carrier is primary.

Vision Care Benefits

Your vision benefit is administered by Davis Vision, which maintains a national **network** of vision providers. If you need an eye exam, corrective lenses (including contact lenses) or frames, you can go to a **participating provider** or a non-participating provider. By using a **participating provider**, you can get an exam and glasses with no out-of-pocket cost, but your choice of frames will be limited to the Plan's selection. If you want frames and/or lenses that cost more than the Plan's limit, you will pay the difference.

If you use a non-participating provider, you can get up to $30 for eye exams, $60 for lenses and $60 for frames. You will be responsible for paying the charges in full and will be reimbursed up to the **allowed amounts**.

There is no **out-of-network** benefit for participants and dependent(s) under age 19.

If you get contact lenses instead of frames and lenses, from either a participating or non-participating provider, the maximum reimbursement for the contact lenses is $120. If you use a **participating provider**, your eye exam is free. If you use a non-participating provider, you can get up to $30 for your eye exam. You will be responsible for paying any charges in excess of the maximum reimbursement.

These maximum benefits are payable within any 24-month period,[(5)] starting with the date you first incur a vision care expense (typically an eye exam). For example, if you get an eye exam on September 1, 2015, you have up to September 1, 2017 (assuming you remain eligible for Fund benefits) to receive the benefits cited above for the lenses and frames or contacts. Any unused vision care benefits cannot be carried over and used in a subsequent 24-month period.

[(5)] Participants and dependent(s) under 19 are eligible for an eye exam once every 12 months.

You can access your Vision Plan benefits by:

- Showing your Davis Vision card to a Davis Vision provider, or
- Visiting a non-participating provider and later submitting a Vision Plan claim form to Davis Vision for reimbursement.

To find a **participating provider**, call Member Services at 1-800-999-5431.

Eligible Expenses

The Plan covers the following vision care expenses:

- eye examinations performed by a legally qualified and licensed ophthalmologist or optometrist, and
- prescribed corrective lenses you receive from a legally qualified and licensed optician, ophthalmologist or optometrist.

Excluded Expenses

The Plan's vision care coverage will not reimburse or make payments for expenses incurred for, caused by or resulting from:

- ophthalmic treatment or services payable under the provisions of any other benefits of the plan (opthalmic treatment may be covered under the hospital/medical benefits described on pages 34–47),
- non-prescription eyeglasses,
- adornment expenses, and
- **out-of-network** benefits for participants and dependent(s) under age 19.

Life Insurance Benefits

Benefit Amount

Your life insurance coverage, which is administered by MetLife, is $15,000. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

Naming a Beneficiary

Your beneficiary will be the person or persons you name in writing on a form that is kept on file at MetLife. To obtain a beneficiary form, contact MetLife at 1-866-492-6983. Your beneficiary can be anyone you choose, and you can change your beneficiary designation at any time by completing and submitting a new form to MetLife. You can get a MetLife beneficiary form by going to www.32bjfunds.org, selecting the 32BJ Health Fund tab and clicking forms.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your life insurance benefit will be payable in the following order:

1) your spouse, if living,

2) your living children, equally,

3) your living parents, equally, and

4) if none of the above, to your estate.

The Plan does not pay life insurance benefits to a designated beneficiary who is involved in any way in the purposeful death of the participant. In a case where this rule applies, if there is no named beneficiary who can receive the benefits, they will be paid in the order listed immediately above.

Life Insurance Disability Extension

If you are disabled and receiving Short-Term Disability or Workers' Compensation benefits, your life insurance will continue for six months from the date of disability, or until your disability ends, whichever happens first. For as long as this extended coverage lasts, your benefit level will be frozen at the level in effect at the time you became disabled.

If you die before you submit proof of your disability, your beneficiary must submit proof of death and total disability within 90 days after your death.

Notice of approval or denial of benefits will be sent to your designated beneficiary in writing. (See page 86 for information on appealing a denied claim.)

When Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, except as provided above. (See pages 16–18.) See page 113 for information about converting your group life insurance to an individual life insurance policy.

Accidental Death & Dismemberment (AD&D) Benefits

Accidental Death & Dismemberment ("AD&D") Insurance, which is administered by MetLife, applies to accidents on or off the job, at home or away from home. This is unlike Workers' Compensation insurance, which covers you only on the job. You are eligible while in **covered employment** and for 30 days after your **covered employment** ends. Your AD&D benefit is in addition to your life insurance and is payable if you die or become dismembered as a result of an accident *within 90 days* after that accident.

How AD&D Benefits Work

If you lose your life in an accident, or both hands at or above the wrist, or both feet at or above the ankle, or sight in both eyes, or any combination of

hand, foot, and sight in one eye, the AD&D benefit payable to your beneficiary is $15,000. If you lose one hand at or above the wrist, or one foot at or above the ankle, or sight in one eye, the AD&D benefit payable is $7,500.

"Loss" of a hand or foot means the actual and complete severance through or above the wrist or ankle joint. Loss of sight means the irrevocable and complete loss of sight.

For all covered losses caused by all injuries that you sustain in one accident, not more than the full amount will be paid.

Contact MetLife to claim AD&D benefits.

What Is Not Covered

AD&D insurance benefits will not be paid for injuries that result from any of the following causes:

- physical or mental illness, or diagnosis of or treatment for the illness,
- an infection, unless it is caused by an external wound,
- suicide or attempted suicide,
- intentionally self-inflicted injury,
- the use of any drug, medicine or sedative, unless it is taken or used as prescribed by a **physician** or an over-the-counter drug taken as directed,
- war, whether declared or undeclared,
- an act of war, insurrection, rebellion, riot or terrorist act,
- committing or trying to commit a felony,
- any poison or gas voluntarily taken, administered or absorbed,
- service in the armed forces of any country or international authority, except the United States National Guard,
- operating, learning to operate or serving as a member of a crew of an aircraft:
  - while in any aircraft operated by or under any military authority (other than the Military Airlift Command),
  - while in any aircraft being used for a test or experimental purposes,
  - while in any aircraft used or designed for use beyond the Earth's atmosphere, and
  - while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation), or
- driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle is being operated.

Note that certain exclusions and limitations may be subject to state-specific requirements.

When Coverage Ends

AD&D insurance coverage ends 30 days after you terminate employment.

New York State Short-Term Disability Benefits Law

The Fund provides statutory short-term disability ("STD") benefits to participants who work in the state of New York and whose **employers** have opted to provide statutory short-term disability through the Fund. Contact your **employer** to determine whether you are covered by the Fund.

Statutory STD benefits provide a weekly income to you if you become sick or disabled while working in **covered employment** (or within four weeks after termination of employment). This means that you are unable to perform the duties of your regular job because of a covered accident or sickness and are under the care of a legally recognized healthcare practitioner.

To be eligible for STD benefits, you must meet the following criteria:

- You must be considered disabled as defined by the New York State Short-Term Disability Benefits Law ("DBL"),
- You are under the care of a non-related legally recognized healthcare practitioner, and
- Your disability is not the result of a job related or on the job injury or illness.

STD Benefit Amount. The STD benefit payable from the Plan is as follows:

- 50% of your current average gross weekly earnings up to a maximum of $170/week.

When Benefits Begin. Benefits commence on the eighth day of continuous disability following an illness or accident.

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks.

When Benefits End. Benefits end when any of the following events occurs:

- You are no longer disabled,
- You are able to perform the regular duties of your own job,
- You perform work for remuneration or profit,
- You fail to provide proof of loss as required by the benefit administrator,
- You no longer receive regular and appropriate care for the condition you are claiming disability, or
- You have received the maximum number of weeks of benefits.

Benefit Limitations and Exclusions. The following limitations and exclusions apply to this benefit:

- Your disability will not begin until you have visited a legally recognized healthcare practitioner for the illness or injury that caused the disability.
- Each period of disability is assessed against certain disability duration standards based upon the diagnosis and job duties and may require additional medical documentation or examination as required by the benefit administrator.
- Two periods of disability due to the same or a related illness will be treated as a recurring disability if said disability recurs within 90 days after you were last entitled to benefits, provided all plan provisions are met.
- Benefits will only be paid during periods when loss of wages occurs.
- Gross weekly benefits may be reduced if you are receiving disability benefits under the United States Social Security Act, as well as other sources of income listed in the DBL plan.
- Any disability resulting from the willful intent of the individual to bring harm to him or herself, or another individual.
- Any disability resulting from the perpetration of an illegal act.
- Any period of time during which the individual receives monies from his or her employer, etc., and said amount is equal to or greater than the eligible amount under this plan.
- Any disability due to an act of war.

Receiving STD Benefits. Effective for disability dates on or after June 1, 2015, your STD benefits are administered by the Guardian Life Insurance Company of America. Contact Guardian TeleGuard at 1-888-262-5670, Monday through Friday 8:00 am–8:00 pm to apply for STD benefits.

Note: This document serves only as an overview of the New York State Short-Term Disability Benefits Law ("DBL") program and it is not a guarantee of coverage or payment. All STD claims are administered under the terms and laws set forth by the New York State Workers' Compensation Board.

Claims and Appeals Procedures

This section describes the procedures for filing claims for Plan benefits. It also describes the procedure for you to follow if your claim is denied, in whole or in part, and you wish to appeal that decision.

Claims for Benefits

A claim for benefits is a request for Plan benefits that is made in accordance with the Plan's claims procedures. Please note that the following are **not** considered claims for benefits:

- inquiries about the Plan's provisions or eligibility that are unrelated to any specific benefit claim,
- a request for prior approval of a benefit that does not require prior approval by the Plan, and
- presentation of a prescription to be filled at a pharmacy that is part of the CVS Caremark **network** of participating pharmacies. However, if you believe that your prescription has not been filled by a participating pharmacy in accordance with the terms of the Plan, in whole or in part, you may file a claim using the procedures described on this page and the following pages.

Filing Hospital, Medical, Mental Health and Substance Abuse Claims

If you use **network** providers, you do not have to file claims. The providers will do it for you. If you use **out-of-network** providers, here are some steps to take to make sure your hospital, medical, mental health and substance abuse claim gets processed accurately and on time:

- **File claims as soon as possible and never later than 180 days after the date of service.** Refer to the table on page 88 for information on where to file your claim for benefits received **out-of-network**. Claims filed more than 180 days after the date of service will be denied.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation. Claims not in English will not be processed and will be returned to you.
- Attach original bills or receipts. Photocopies will not be accepted.
- If you have other coverage and the Fund is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits ("EOB") with your itemized bill. (See Coordination of Benefits on pages 97–100.)
- Keep a copy of your claim form and all attachments for your records.

Filing Pharmacy Claims

If you use participating pharmacies or the mail order pharmacy, you do not have to file claims. The participating pharmacies or mail order pharmacy will do it for you. If you use an **out-of-network** pharmacy, then you must file a claim for benefits. Refer to the table on page 88 for information on where to file your claim for benefits received **out-of-network**. **Pharmacy claims should be filed as soon as possible, but never later than 180 days after the date the prescription was filled. Claims filed more than 180 days after the date of service will be denied.**

If you have other coverage and the Fund is the secondary payer, submit the original or a copy of the primary payer's EOB with your itemized bill. (See Coordination of Benefits on pages 97–100.)

Filing Dental Claims

When you see a participating dental provider, this provider will file all claims for you directly with ASO, Inc., the administrator for the Plan's dental coverage. ASO, Inc. will pay the participating dental providers directly.

You have to file a claim when you receive care from dentists or other providers or facilities not in the Plan's participating dental provider **network**. You can obtain a claim form by visiting ASO, Inc.'s web site at www.asonet.com. Here is what you need to know when you file a dental claim when you do not use a participating dental provider:

- Only an original, fully completed American Dental Association ("ADA") claim form or approved treatment plan will be accepted for review.
- All necessary diagnostic information must accompany the claim.
- When you are the patient, your original signature or signature on file is acceptable on all claims for payment. If the patient is a child, an original signature or signature on file of the child's parent or guardian is acceptable.
- **All claims must be received by ASO, Inc. within 180 days after services were rendered. Claims filed more than 180 days after the date of service will be denied.**
- You, or your dentist, can return the approved treatment plan (if it was secured before your treatment began) with the submission of your claim.
- If you, or your dentist, received an approved treatment plan prior to beginning your treatment, this approved treatment plan is only valid for one year from the date it was issued. In addition, an approved treatment plan cannot be used by any person other than the person to whom it was issued. ASO, Inc. reserves the right to withhold payment or request reimbursement from providers or participants for services that do not meet acceptable standards, as determined by its consultants or professional staff.
- The Fund does not accept assignment of payment to an **out-of-network** dentist. This means if you use an **out-of-network** dentist, the Fund does not make payment directly to that dentist. You will have to pay the dentist first, and you will be reimbursed according to the Plan's coverage limits.

Filing Vision Claims

If you use participating vision providers, you do not have to file claims. The providers will do it for you. If you do not use a participating vision provider, then you must file a vision claim with Davis Vision for reimbursement of eligible expenses. Refer to the table on page 81 for information on where to file your claim for benefits received **out-of-network**. You can obtain a vision claim form from Member Services. **Vision claims should be filed as soon as possible, but never later than 180 days after the date of service. Claims filed more than 180 days after the date of service will be denied.**

Filing Life Insurance and AD&D Claims

To file a claim for a life insurance benefit, your beneficiary must complete a claim form and submit a certified copy of your death certificate. **A claim for life insurance should be filed as soon as possible after the participant's death.**

To file for an AD&D benefit, you must complete a claim form. In the event of your death, your beneficiary must submit a certified copy of your death certificate along with a completed claim form. **A claim for an AD&D benefit must be filed within 90 days after the loss is incurred.**

For both life insurance and AD&D claims, you can get claim forms by contacting MetLife.

Filing for a Short-Term Disability Benefit

Effective June 1, 2015, to file a claim for Short-Term Disability ("STD") benefits, contact Guardian TeleGuard at 1-888-262-5670, Monday through Friday 8:00 am–8:00 pm to apply. All claims for STD must be filed by phone. A claim for STD should be filed within 30 days of the onset of the disability. If filed late, you may not be paid for any disability period greater than two weeks before the claim is filed. Claims filed after 26 weeks will be denied.

Where to Send Claim Forms

Benefit	Filing Address
Hospital, Medical, Mental Health and Substance Abuse (**out-of-network** only; no claim forms are necessary for **in-network** care)	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Attn: Institutional Claims Department (for hospital claims); or, Attn: Medical Claims Department (for medical/ professional/ambulance claims)
Pharmacy (non-participating providers only; no claim forms are necessary for **participating providers**)	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136
Dental (non-participating providers only; no claim forms are necessary for **participating providers**)	Administrative Services Only, Inc. (ASO, Inc.) Building Service 32BJ Health Fund Dedicated Unit P.O. Box 9011 Lynbrook, NY 11563-9011
Vision (non-participating providers only; no claim forms are necessary for **participating providers**)	Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110
Life Insurance Accidental Death & Dismemberment	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100
Short-Term Disability* (Effective June 1, 2015)	Guardian TeleGuard at 1-888-262-5670

*All claims for Short-Term Disability benefits must be filed by phone.

Approval and Denial of Claims

There are separate claims denial and approval processes for Health Services Claims (hospital, medical, mental health and substance abuse), Ancillary Health Services Claims (pharmacy, dental and vision), Life/AD&D Claims, and Short-Term Disability Claims. These processes are described separately below. Please review this information to ensure that you are fully aware of these processes and what you need to do in order to comply.

Health Services Claims (Hospital, Medical, Mental Health and Substance Abuse) and Ancillary Health Services Claims (Pharmacy, Dental and Vision)

The time frames for deciding whether Health Services and Ancillary Health Services claims are approved or denied depends on whether your claim is a pre-service, an urgent care, a concurrent care or a post-service claim.

- *Pre-service claims*. This is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Prior approval of services is required for inpatient hospital benefits (see pages 30–32), certain outpatient hospital benefits (see pages 30–32), behavioral health and substance abuse benefits (see pages 30–32) and for certain dental benefits (see pages 60–69). For properly filed pre-service claims, you and/or your **doctor** or dentist will be notified of a decision *within 15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the claims reviewer. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

  If you improperly file a pre-service claim, you will be notified as soon as possible, but not later than *five days* after receipt of the claim, of the proper procedures to be followed in refiling the claim. You will only receive notice of an improperly filed pre-service claim if the claim includes:

  – your name,

  – your current address,

  – your specific medical condition or symptom, and

  – a specific treatment, service or product for which approval is requested.

Unless the claim is refiled properly, it will not constitute a claim. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your **doctor** will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.

During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for *45 days* or until the date the claims reviewer receives your response to the request (whichever is earlier). The claims reviewer will then have *15 days* to make a decision on a pre-service claim and notify you of the determination.

- *Urgent care claims*. This is a claim for medical care or treatment that, if the time periods for making pre-service claim determinations were applied, could jeopardize your life, health or ability to regain maximum function or, in the opinion of a **doctor**, result in your having unmanageable, severe pain.

  Whether your treatment is considered urgent care is determined by an individual acting on behalf of the Fund applying the judgment of a prudent person who possesses an average knowledge of health and medicine. Any claim that a **doctor** with knowledge of your medical condition determines is an urgent care claim shall automatically be treated as such.

  If you (or your authorized representative*) file an urgent care claim, you will be notified of the benefit determination as soon as possible, taking into account medical emergencies, but no later than *72 hours* after receipt of your claim.

  However, if you do not give enough information for the claims reviewer to determine whether, or to what extent, benefits are payable, you will receive a request for more information *within 24 hours*. You will then have up to *48 hours*, taking into account the circumstances, to provide the specified information to the claims reviewer. You will then be notified of the benefit determination *within 48 hours* after:

* A health care professional with knowledge of your medical condition, or someone to whom you have given authorization may act as an authorized representative in connection with urgent care.

– the claims reviewer's receipt of the specified information or, if earlier,

– the end of the period you were given to provide the requested information.

If you do not follow the Plan's procedures for filing an urgent care claim, you will be notified *within 24 hours* of the failure and the proper procedures to follow. This notification may be oral, unless you request written notification. You will only receive notification of a procedural failure if your claim includes:

– your name,

– your specific medical condition or symptom, and

– a specific service, treatment or product for which approval is requested.

- *Concurrent care claims*. This is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if additional days are appropriate. Here, the decision to reduce, end or extend treatment is made while the treatment is taking place.

  Any request by a claimant to extend approved treatment will be acted upon by the claims reviewer *within 24 hours* of receipt of the claim, provided the claim is received at least *24 hours* before the approved treatment expires.

- *Post-service claims*. This is a claim submitted for payment after health services and treatment have been obtained.

  Ordinarily, you will receive a decision on your post-service claim *within 30 days* from receipt of the claim. This period may be extended one time for up to *15 days* if the extension is necessary due to extraordinary matters. 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 determination will be made.

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

During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for *45 days* or until the date the claims reviewer receives your response to the request (whichever is earlier). *Within 15 days* after the expiration of this time period, you will be notified of the decision.

Life and AD&D Claims

If you, or your beneficiary, file a claim for either Life or AD&D benefits, MetLife will make a decision on the claim and notify you of the decision *within 90 days*. If MetLife requires an extension of time due to matters beyond its control, they are permitted an additional *90 days*. MetLife will notify you, your authorized representative, your beneficiary or the executor of your estate, as applicable, before the expiration of the original 90-day period of the reason for the delay and when the decision will be made. A decision will be made within the 90-day extension period and you will be notified in writing by MetLife.

Short-Term Disability Benefit Claims

If you file a claim for STD benefits, Guardian will typically make a decision on the claim within four (4) business days of receipt of the claim assuming they are successful in obtaining all needed information. If Guardian requires an extension of time due to matters beyond its control, a Guardian representative will contact you.

Notice of Decision

You will be provided with written notice of a denial of a claim that sets forth the reason(s) for denial, whether denied in whole or in part, or if any adverse benefit determination is made (for example, the Plan pays less than 100% of the claim). For urgent care and pre-service claims, you will receive notice of the determination even when the claim is approved. The timing for delivery of this notice depends on the type of claim as described on pages 82–86.

Appealing Denied Claims

An appeal is a request by you, or your authorized representative, to have an adverse benefit determination reviewed and reconsidered. There are different appeals processes for Health Services Claims (hospital, medical, mental health and substance abuse), Ancillary Health Services Claims (pharmacy, dental and vision), Life/AD&D Claims, and Short-Term Disability Benefit Claims.

The table below gives a brief overview of with whom an appeal should be filed and the levels of appeal available for each type of denied claim:

Type of Denied Claim	Level-one Appeal	Level-two Appeal
Health Services Claims (Medical Judgment)	Empire BlueCross BlueShield	Independent Review Organization ("IRO")
Health Services Claims (Administrative)	Empire BlueCross BlueShield	Board of Trustees*
Ancillary Health Services Claims:		
• Pharmacy (Medical Judgment)	CVS Caremark	Independent Review Organization ("IRO")
• Pharmacy (Administrative)	CVS Caremark	Board of Trustees*
• Dental	ASO, Inc.	Board of Trustees*
• Vision	Davis Vision	Board of Trustees*
Life/AD&D	MetLife Insurance Company	Board of Trustees*
Short-Term Disability Benefits	Workers' Compensation Board	Not applicable

*This level of appeal is voluntary.

Filing an Appeal

For all types of claims, you have *180 days* from the date of the original claim denial notification letter to file a level-one appeal following the notification of a denied claim.

Your appeal must include your identification number, dates of service in question and any relevant information in support of your appeal.

If you submit an appeal, you will be provided, free of charge, access to, or copies of, all documents, records or other information relevant to your appeal (including, in the case of an appeal involving a disability determination, the identity of any medical or vocational experts whose advice the claims reviewer used in connection with the decision to deny your application).

A document, record or other information is relevant for review if it falls into any of the following categories:

- The claims reviewer relied on it in making a decision.
- It was submitted, considered or generated in the course of making a decision (regardless of whether it was relied on).
- It demonstrates compliance with the claims reviewer's administrative processes for ensuring consistent decision-making.
- It constitutes a statement of Plan policy regarding the denied treatment or service.

You (or your authorized representative) may submit issues, comments, documents and other information relating to the appeal (regardless of whether they were submitted with your original claim).

If you do not request a review of a denied claim within 180 days of the date of the denial, you will waive your right to a review of the denial. You must file an appeal with the appropriate party and follow the process completely before you can bring an action in court. Failure to do so may prevent you from having any legal remedy.

Where to File a Level-One Appeal

Benefit	Write to:	Or Call
Hospital Medical Mental Health Substance Abuse	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407	1-866-316-3394
Pharmacy	Prescription Claims Appeals CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172	Appeals are only accepted in writing*
Vision	Davis Vision, P.O. Box 791 Latham, NY 12110	Appeals are only accepted in writing
Dental	ASO, Inc. Dental Benefits Processing Group P.O. Box 676 New York, NY 10013-0819	Appeals are only accepted in writing**
Life Insurance Accidental Death & Dismemberment	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 1-570-558-8645	Appeals are only accepted in writing
Short-Term Disability Benefits	Workers' Compensation Board Disability Benefits Bureau 100 Broadway – Menands Albany, NY 12241-0005	Appeals are only accepted in writing

* An appeal of an urgent care clinical claim may be filed orally by calling Customer Care at 1-877-765-6294 or your **physician** may call 1-800-294-5979.

** An appeal of an urgent care dental claim may be filed orally by calling 516-394-9485.

Time Frames for Decisions on Appeals

The time frame within which a decision on an appeal will be made depends on the type of claim for which you are filing an appeal.

Expedited Appeals for Urgent Care Claims

If your claim involves urgent care for Health Services (hospital, medical, mental health and substance abuse) or certain Ancillary Health Services (pharmacy or dental) benefits, you can file an expedited appeal if 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. This appeal can be filed in writing or orally. You can discuss the reviewer's determination and exchange any necessary information over the phone, via fax or any other quick way of sharing. You will receive a response *within 72 hours* of your request.

Pre-Service or Concurrent Care Health Services (Hospital, Medical, Mental Health and Substance Abuse) or Ancillary Health Services (Pharmacy, Dental or Vision) Claim Appeal

If you file an appeal of a pre-service (service not yet received) or concurrent care (service currently being received) claim that does not involve urgent care, a decision will be made and you will be notified *within 30 days* of the receipt of your appeal. An appeal of a cessation or reduction of a previously approved benefit will be decided as soon as possible, but in any event prior to the cessation or reduction of the benefit.

Post-Service Health Services (Hospital, Medical, Mental Health and Substance Abuse) or Ancillary Health Services (Pharmacy, Dental or Vision) Claim Appeal

If you file an appeal of a post-service claim, a decision will be made and you will be notified *within 60 days* of the receipt of your appeal.

Request for Expedited Appeal

You may request that the appeal process be expedited if (1) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or, in the opinion of your **doctor**, would cause you severe pain which cannot be managed without the requested services or drugs; or (2) your appeal involves non-authorization of an admission or a continuing inpatient hospital stay. Empire's **physician** reviewer or CVS Caremark's independent medical specialist, as applicable, in consultation with the treating **physician**, will decide if an expedited appeal is necessary. When an appeal is expedited, Empire or CVS Caremark will respond orally with a decision *within 72 hours*, and Empire or CVS Caremark will also send a written notice of the decision.

Second Level of Appeal for Claims Involving Medical Judgment or a Retroactive Rescission of Coverage

Health Services Claims (Hospital, Medical, Mental Health and Substance Abuse) and Pharmacy Claims

Health Services Claims. If you are not fully satisfied with the decision of Empire's level-one appeal decision of a claim that involved Medical Judgment, or retroactive rescission of coverage, you may request that your appeal be sent to an Independent Review Organization ("IRO") for review. The IRO is composed of persons who are not employed by Empire, or any of its affiliates, or the Fund. A decision to request an appeal to an IRO will not affect your rights to any other benefits under the Plan.

There is no charge for this independent review process. The Plan will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a Medical Judgment or clinical appropriateness determination by Empire. As noted above, Medical Judgment means a determination based on, but not limited to, the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational. Administrative, eligibility, or benefit coverage limits or exclusions are not eligible for review by the IRO.

To request a review, you must notify Empire *within four months* of the date of Empire's level-one appeal denial letter. Empire will then forward the file to the IRO. The IRO will provide written notice of its decision *within 45 days*.

When requested, and if a delay would be detrimental to your medical condition, as determined by Empire's **physician** reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received **emergency** services, but you have not yet been discharged from a facility, the IRO review shall be completed *within 72 hours*.

*Pharmacy Claims***.** If you are not fully satisfied with the decision of CVS Caremark's level-one appeal review of a claim that involved Medical Judgment, you may request that your appeal be sent to an IRO for review. The IRO is composed of persons who are not employed by CVS Caremark, or any of its affiliates. A decision to request an appeal to an IRO will not affect your rights to any other benefits under the Plan.

There is no charge for this independent review process. CVS Caremark will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a Medical Judgment or clinical appropriateness determination by CVS Caremark. As noted above, Medical Judgment means a determination based on, but not limited to, the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational. Administrative, eligibility, or benefit coverage limits or exclusions are not eligible for review by the IRO.

To request a review, you must notify CVS Caremark *within four months* of the date of CVS Caremark's level-one appeal review denial letter. CVS Caremark will then forward the file to the IRO. The IRO will provide written notice of its decision *within 45 days*.

When requested, and if a delay would be detrimental to your medical condition, as determined by CVS Caremark's independent medical specialist, the IRO review shall be completed *within 72 hours*.

External Review Process

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

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

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

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

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

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

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

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

Reversal of the Fund's decision. If the IRO issues a final decision that reverses the prior decision, the claim will be paid.

Voluntary Level of Appeal

Administrative Health Services and Pharmacy Claims, Ancillary Health Services Claims (Dental and Vision), and Life/AD&D Claims

Once you have received notice of the denial of your timely[6] level-one appeal of an administrative[7] Health Services or Pharmacy Claim, or level-one appeal of an Ancillary Services Claim (dental or vision), or a Life/AD&D Claim, you have exhausted all required internal appeal options.

If you disagree with the decision, you are free to file a civil action under Section 502(a) of Employee Retirement Income Security Act of 1974 ("ERISA"). You may not start a lawsuit to obtain benefits until you have completed the mandatory appeals process and a final decision has been reached, or until the appropriate time frame described in the SPD has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. I**n addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied.** In addition, all claims for benefits against the Fund must be brought in the federal courts located in New York. Alternately, you may file a voluntary appeal with the Board of Trustees. This voluntary appeal must be filed *within 180 days* of the date of the appeal denial letter provided to you by the applicable reviewer as listed in the table under the section Appealing Denied Claims.

The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan, as described previously. This level of appeal is *completely voluntary*; it is not required by the Plan and is only available if you (or your representative) request it. 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. The Plan will not impose fees or costs on you (or your representative) because you (or your authorized representative) choose to invoke the voluntary appeals process. Your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan. Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including your right to representation.

Your voluntary appeal must include your identification number, dates of service in question and any additional information that supports your appeal. You (or your authorized representative) can write to the Board of Trustees at the following address:

32BJ North Health Fund
Board of Trustees – Appeals
25 West 18th Street
New York, NY 10011-4676

If you (or your authorized representative) chooses to pursue a claim in court after completing the voluntary appeal, the statute of limitations applicable to your claim, which is three years under the terms of the Plan, will be tolled (suspended) during the period of the voluntary appeals process.

Appeal Decision and Notice

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

Life Insurance and AD&D Claim Appeal

Under ERISA, if your claim is denied, in whole or in part, you or your authorized representative may request the adverse determination be reviewed and reconsidered by filing a written appeal with MetLife. Your appeal must be made within one hundred eighty (180) days of the date the claim is denied and be mailed to:

MetLife
P.O. Box 6100
Scranton, PA 18505

[6] The Board of Trustees does not hear voluntary appeals for claims for which the mandatory appeals were not timely filed with the appropriate appeals reviewer. If your appeal was denied as untimely by the appeals reviewer, there is no voluntary appeal to the Board of Trustees'.

[7] An administrative Health Services or Pharmacy Claim is one which did not involve Medical Judgment. An administrative claim could include, for example, a claim that a benefit exceeded the plan limit or was not a covered service or drug.

If you fail to appeal within one hundred eighty (180) days, you will waive your right to a review of the denial.

Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate to enable MetLife to give your appeal proper consideration. Upon your written request, MetLife will provide you with a copy of the records and/or reports that are relevant to your claim.

MetLife will carefully evaluate all the information and advise the claimant of its decision within sixty (60) days after the receipt of the appeal. If there are special circumstances requiring additional time to complete the review, we may take up to an additional sixty (60) days, but only after notifying the claimant of the special circumstances in writing.

STD Claim Appeal

If your claim for disability benefits is rejected, in whole or in part, you may file an appeal within 26 weeks from the date of the Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451).

Appeals are only accepted in writing. To appeal a denied claim, you must complete the reverse side of the denial form (Form DB-451), under the heading "Claimant's Request for Review" and submit two copies to:

Workers' Compensation Board
Disability Benefits Bureau
100 Broadway–Menands
Albany, NY 12241-0005

If you file an appeal of an STD claim with the Workers' Compensation Board Disability Benefits Bureau, you will be notified in writing by the Workers' Compensation Board. Benefits will be paid if a claim is proper and valid.

Further Action

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

You may not start a lawsuit to obtain benefits until you have completed the mandatory appeals process and a final decision has been reached, or until the appropriate time frame described in this booklet has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **In addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied.** In addition, all claims for benefits against the Fund must be brought in the federal courts located in New York. If there is no decision on the appeal, no lawsuit may be started more than three years after the time when the Board of Trustees should have decided the appeal.

If you have any questions about the appeals process, please contact the Compliance Office. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

Incompetence

If someone who is entitled to benefits from the Plan is determined to be unable to care for his or her affairs because of illness, accident or incapacity, either mental or physical, any payment due may be made instead to someone else, such as a spouse or a legal custodian. The Fund will decide who is entitled to benefits in cases like this.

Mailing Address

It is important that you notify Member Services whenever your address changes. If you become unreachable, the Fund will hold any benefit payments due you, without interest, until payment can be made. You are considered unreachable if a letter sent to you by first-class mail to your last known address is returned.

Coordination of Benefits

You, or your dependent(s), may have health care coverage under two plans. For example, your spouse may have employer-provided health insurance or be enrolled in Medicare. When this happens, the two plans will coordinate their benefit payments so that the combined payments do not exceed the allowable charges (or actual cost, if less). This process, known as Coordination of Benefits ("COB"), establishes which plan pays first and which one pays second. The plan that pays first is the primary plan; the plan that pays second is the secondary plan. The primary plan may reimburse you first and the secondary plan may reimburse you for the remaining expenses to the maximum of the allowable charges for the **covered services**.

The Plan uses the Non-Duplication of Benefits application of COB. This means that when this Plan is the secondary plan, it determines how much it would have paid as the primary plan and then subtracts whatever the primary plan paid as its benefit. Then this Plan, the secondary plan, pays the difference. If there is no difference, then this plan, as the secondary plan, pays nothing.

COB will ensure that you receive the maximum benefit allowed by the Plan, while possibly reducing the cost of services to the Plan. You will not lose benefits you are entitled to under this Plan and may gain benefits if your spouse's plan has better coverage in any area.

Except for the situations such as Medicare and **TRICARE,** as described on the following page, the rules for determining which plan is primary are as follows:

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

If both you and your spouse are participants under this Plan, your benefits are coordinated in the same manner as anyone else (that is, as if you and your spouse were covered under different plans). You will not receive reimbursement for more than the allowable charges for the **covered services**, and you will not be reimbursed for required **co-payments**.

Medicare

- If you, or your dependent(s), become eligible for Medicare due to age or disability (according to the standards applied by Social Security) and you are in **covered employment**, you, or your dependent(s), can keep or cancel (spouse can cancel when he or she reaches age 65) your coverage under this Plan. If you (or your dependent(s)) decide to be covered by both this Plan and Medicare, this Plan will be primary and Medicare will be secondary as long as you remain in **covered employment**.
- If you are not in **covered employment** (for example, you have extended health coverage while receiving disability benefits) and you (or your dependent(s)) are eligible for Medicare due to age or disability (according to the standards applied by Social Security), Medicare is primary and this Plan is secondary for each covered family member who is eligible for Medicare. Those covered family members who are not eligible for Medicare continue to receive primary coverage from this Plan.

End-stage Renal Disease. For covered patients with end-stage renal disease, Medicare is the secondary payer of benefits during the first 30 months of treatment. After this 30-month period is over, Medicare permanently becomes the primary payer. Note that this Plan will pay as the secondary plan after the 30-month period even if you (or your dependent(s)) fail to enroll in Medicare Part B.

TRICARE. If you, or an eligible dependent, are covered by this Plan and **TRICARE**, this Plan pays first and **TRICARE** pays second.

No-fault Benefits. If a person covered by this Plan has a claim, which involves a motor vehicle accident covered by the "no-fault" insurance law of any state, health care expenses must be reimbursed first by the no-fault insurance carrier. Only when the claimant has exhausted his or her health care benefits under the no-fault coverage will he or she be entitled to receive health care benefits under this Plan. If there are expenses for services that are covered under this Plan and which are not completely reimbursed by the no-fault carrier, such expenses may be reimbursed under this Plan, subject to the

Plan's applicable maximums and other provisions. If you are covered for loss of earnings by any motor vehicle no-fault liability carrier, the disability benefits payable by this Plan will be reduced by any no-fault benefits available to you for loss of earnings.

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

Workers' Compensation. This Plan does not provide benefits for expenses covered by Workers' Compensation or occupational disease laws. If an **employer** disputes the application of Workers' Compensation law for the illness or injury for which expenses are incurred, the 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 (for information about subrogation and reimbursement of benefits, see pages 101–104).

Your Disclosures to the Fund: Fraud

Everyone who is entitled to claim benefits from the Plan must furnish to the Fund all necessary information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Plan. Failure to comply with such requests promptly and in good faith will be sufficient grounds for delaying or denying payment of benefits. The Board will be the sole judge of the standard of proof required in any case, and may periodically adopt such formulas, methods and procedures as the Board considers advisable.

The information you give to the Fund, including statements concerning your age and marital status, affects the determination of your benefits. If any of the information you provide is false, or if you perform an act or practice constituting fraud, or make an intentional misrepresentation of material fact, you may be required to indemnify and repay the Fund for any losses or damages caused by your false statements, fraud or misrepresentation. In addition, if a claim has been submitted for payment or paid by the Fund as a result of false statements, fraud or misrepresentation, the Fund may seek reimbursement, may elect to pursue the matter by pressing criminal charges and may take any other action deemed reasonable. Knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution. Your failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependency status or accepting benefits after your eligibility ends, will be considered fraud.

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

The Fund regularly evaluates claims to detect fraud or false statements. The Fund must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds **co-payments** or **co-insurance** is entering into a discount arrangement with you unless that provider has a preapproved written agreement with the Fund for that kind of waiver or refund. If you are not sure that your provider has such a preapproved written agreement, you may call Member Services at 1-800-551-3225 for assistance.

The Fund calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers, or refunds of **co-payments**, **co-insurance** or **deductibles**, where applicable, to member's plan.

Subrogation and Reimbursement

If another party or other source makes payments relating to a sickness or injury for which benefits have already been paid under the Plan, then the Fund is entitled to recover the amount of those benefits. You, and your dependent(s), may be required to sign a reimbursement agreement if you seek payment of medical expenses relating to the sickness or injury under the Plan before you have received the full amount you would recover through a judgment, settlement, insurance payment or other source. In addition, you, and your dependent(s), may be required to sign necessary documents and to promptly notify the Fund of any legal action.

If you, or your dependent(s), are injured as a result of negligence or other wrongful acts, whether caused by you, your dependent(s) or by another party, and you, or your dependent(s), apply to this Fund for benefits and receive

such benefits, this Fund shall then have a first priority lien for the full amount of those benefits should you recover any monies from any party that caused, contributed to or aggravated the injuries or from any other source otherwise responsible for payment thereof. This first priority lien applies whether these monies come directly from your own insurance company, another person or his or her insurance company, or any other source (including, but not limited to, any person, corporation, entity, uninsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage or no-fault automobile coverage, or any other insurance policy or plan).

This lien arises through operation of the Plan. No additional subrogation or reimbursement agreement is necessary. The Fund's lien is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from any source.

Any and all amounts received from any party or any other source by judgment, settlement or otherwise, must be applied first to satisfy your reimbursement obligation to the Fund for the amount of medical expenses paid on your behalf or on your dependent's behalf. The Fund's lien is a lien of first priority for the entire recovery of funds paid on your behalf. Where the recovery from another party or any other source is partial or incomplete, the Fund's right to reimbursement takes priority over you, or your dependent's, right of recovery, regardless of whether or not you, or your dependent, have been made whole for his or her injuries or losses. The Fund does not recognize, and is not bound by, any application of the "make whole" doctrine.

The Board has the discretion to interpret any vague or ambiguous term or provision in favor of the Fund's subrogation or reimbursement rights.

By applying for and receiving benefits under the Fund, you agree:

- to restore to the Fund the full amount of the benefits that are paid to you and/or your dependent(s) from the proceeds of any compromise, settlement, judgment and/or verdict, to the extent permitted by law,
- that the proceeds of any compromise, settlement, judgment and/or verdict received from another party, an insurance carrier or any other source, if paid directly to you (or to any other person or entity), will be held by you (or such other person or entity) in a constructive trust for the Fund. (The same rules apply to any other person to whom you assign your rights.) The recipient of such proceeds is a fiduciary of the Fund with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The Fund reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Fund's subrogation or reimbursement rights,
- that any lien the Fund may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in an action to recover from another party or any other source, and these expenses may not be used to offset your obligation to restore the full amount of the lien to the Fund, and
- that any recovery will not be reduced by, and is not subject to, the application of the common fund doctrine for the recovery of attorney's fees.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of another party, or if injuries resulted from your own acts, or the acts of your dependent(s), you should contact your attorney for advice and counsel. However, this Fund cannot, and does not, pay for your attorney fees. The Fund does not require you to seek any recovery whatsoever against another party or any other source, and if you do not receive any recovery, you are not obligated in any way to reimburse the Fund for any of the benefits that you applied for and accepted. However, in the event that you do not pursue any and all third parties or any other responsible sources, the Fund is authorized to pursue, sue, compromise or settle (at the Board's discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims, and you agree to fully cooperate with the Fund in the prosecution of any such claims.

Should you seek to recover any monies from another party or any other source that caused, contributed to, aggravated your injuries or is otherwise responsible, it is a rule of this Plan that you must give notice in writing of same to the Fund within ten days after either you, or your attorney, first attempt to recover such monies, or institute a lawsuit, or enter into settlement negotiations with another or take any other similar action. You must also cooperate with the Fund's reasonable requests concerning the Fund's subrogation and reimbursement rights and keep the Fund informed of any important developments in your action. You must also provide the Fund with any information or documents, upon request, that pertain to, or are relevant to, your actions. If litigation is commenced, you are required to give at least five days written notice to the Fund prior to any action to be taken as part of such litigation including, but not limited to, any pretrial conferences or other court dates. Representatives of the Fund reserve the right to attend such pretrial conferences or other court proceedings.

In the event you fail to notify the Fund as provided for above, and/or fail to restore to the Fund such funds as provided for above, the Fund reserves the right, in addition to all other remedies available to it at law or equity, to withhold or offset any other monies that might be due you, or your dependent(s), from the Fund for past or future claims, until such time as the Fund's lien is discharged and/or satisfied.

For information about subrogation and any impact this may have on your health care claims, contact the Fund's subrogation administrator at the following address:

Meridian Resource Company
P.O. Box 2025
Milwaukee, WI 53201-2025

Overpayments

- If you (or your dependent or beneficiary) are overpaid for a claim, you (or your dependent or beneficiary) must return the overpayment. The Fund will have the right to recover any payments made that were based on false or fraudulent information, as well as any payments made in error. Amounts recovered may include interest and costs. If repayment is not made, the Fund may deduct the overpayment amount from any future benefits from this Fund that you (or your dependent or beneficiary) would otherwise receive, or a lawsuit may be initiated to recover the overpayment.
- If payment is made on your (or your dependent's) behalf to a hospital, **doctor** or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment will be deducted from future benefits payable to the provider, or a lawsuit may be initiated to recover the overpayment.

Continued Group Health Coverage

During a Family and Medical Leave

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

- the birth, adoption or placement with you for adoption of a child,
- to provide care for a spouse, child or parent who is seriously ill,
- your own serious illness, or
- certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status in support of a contingency operation.

In addition, FMLA allows up to 26 weeks of leave in a single 12-month period to care for a covered service member recovering from a serious injury or illness. Eligible employees are entitled to a combined total of up to 26 weeks of all types of FMLA leave during the single 12-month period.

During FMLA leave, you can continue all of your medical coverage and other benefits offered through the Plan. You are generally eligible for a leave under the FMLA if you:

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

Check with your **employer** to determine if you are eligible for FMLA.

The Fund will maintain the employee's eligibility status until the end of the leave, provided the **contributing employer** properly grants the leave under the FMLA and the **contributing employer** makes the required notification and payment to the Fund. Of course, any changes in the Plan's terms, rules or practices that go into effect while you are away on leave apply to you, and your dependent(s), the same as to active employees and their dependent(s). Call Member Services regarding coverage during FMLA leave.

During Military Leave

If you are on active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you, and your dependent(s), at your own expense for up to 24 months provided you enroll for coverage. This continuation coverage operates in the same way as COBRA. (See pages 106–111 for information on COBRA.) In addition, your dependent(s) may be

eligible for health care under **TRICARE**. This Plan will coordinate coverage with **TRICARE.** (See page 99 and page 123.)

When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating **employer**, provided that you return to employment within one of the following time frames:

- 90 days from the date of discharge if the period of military service was more than 180 days,
- 14 days from the date of discharge if the period of military 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 additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Contact Member Services for more details.

Under COBRA

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Fund's hospital, medical, behavioral health and substance abuse, dental, prescription drug and vision coverage.

You do not have to prove that you are in good health to choose COBRA continuation coverage, but you do have to meet the Plan's COBRA eligibility requirements and you must apply for coverage. The Fund reserves the right to end your COBRA coverage retroactively if you are determined to be ineligible.

The following table shows when you, and your eligible dependent(s), may qualify for continued coverage under COBRA, and how long your coverage may continue. Please keep in mind that the following information is a summary of the law and is, therefore, general in nature. If you have any questions about COBRA, please contact Member Services:

COBRA Continuation of Coverage

Coverage May Continue For:	**If:**	**Maximum Duration of Coverage:**
You and your eligible dependent(s)	Your **covered employment** terminates for reasons other than gross misconduct	18 months
You and your eligible dependent(s)	You become ineligible for coverage due to a reduction in your employment hours (e.g., leave of absence)	18 months
You and your eligible dependent(s)	You go on military leave	24 months
Your dependent(s)	You die	36 months
Your spouse and stepchild(ren)	You legally separate, divorce or your marriage is civilly annulled	36 months
Your dependent child(ren)	Your dependent children no longer qualify as dependent(s)	36 months
Your dependent(s)	You terminate your employment or you reduce your work hours less than 18 months after the date of your Medicare (Part A, Part B or both) entitlement	36 months from the date of Medicare entitlement

If you marry, have a newborn child or have a child placed with you for adoption while you are covered under COBRA, you may enroll that spouse or dependent child for coverage for the balance of the COBRA continuation period, on the same terms available to active participants. The same rules about dependent status and qualifying changes in family status that apply to active participants will apply to you and/or your dependent(s). Once COBRA is elected, you cannot transfer between family and single coverage, unless you experience a qualified change in family status.

FMLA leave. If you do not return to active employment after your FMLA leave of absence, you become eligible for COBRA continuation as a result of your termination of employment. For COBRA purposes, your employment is considered "terminated" at the end of the FMLA leave or the date that you give notice to your **employer** that you will not be returning to active employment, whichever happens first.

*Multiple Qualifying Events***.** If your dependent(s) qualify for COBRA coverage in more than one way, they may be eligible for a longer continuation coverage period up to 36 months from the date they first qualified. For example, if you terminate employment, you, and your enrolled dependent(s), may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child stops being eligible for dependent coverage under the Plan (a second Qualifying Event), your child may be eligible for an additional period of continued coverage.

The two periods combined cannot exceed a total of 36 months from the date of your termination (the first Qualifying Event). A second Qualifying Event may also occur if you become legally separated, get legally divorced or die.

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

To make sure you get all of the COBRA coverage you are entitled to, contact Member Services whenever something happens that makes you, or your dependent(s), eligible for COBRA coverage.

Notifying the Fund of a Qualifying Event. Under the law, in order to have a right to elect COBRA coverage, you, or your dependent(s), are responsible for notifying Member Services of your legal separation or divorce, a child losing dependent status under the Plan or if you become disabled (or you are no longer disabled), as determined by the Social Security Administration. You (or your family member) must notify Member Services in writing of any of these events no later than 60 days after the event occurs or 60 days after the date coverage would have been lost under the Plan because of that event, whichever is later. Your notice must include the following information:

- name(s) of the individual(s) interested in COBRA continuation, and the relationship to the participant,
- date of the Qualifying Event, and
- type of Qualifying Event. (See the table of Qualifying Events on page 107.)

*When your **employer** must notify the Fund.* Your **employer** is responsible for notifying the Fund of your death, termination of employment or reduction in hours of employment. Your **employer** must notify the Fund of one of these Qualifying Events within 30 days of the date of the Qualifying Event. Once notified, the Fund will send you a COBRA notice within 14 days.

Making a COBRA election. Once the Fund is notified of your Qualifying Event, you will receive a COBRA notice and an election form. In order to elect COBRA, you, or your dependent(s), must submit the COBRA election form to Member Services within 60 days after the date you would lose health coverage under the Fund or 60 days after the date of the COBRA notice, whichever is later.

Each of your eligible dependent(s) has an independent election right for COBRA coverage. This means that each dependent can decide whether or not to continue coverage under COBRA. If you elect family coverage, you, or your dependent(s), will only be able to convert to single coverage if either you, or your dependent(s), die, you and your spouse divorce or you, or your dependent(s), enroll in Medicare and the Fund terminates your COBRA

coverage. If you elect single coverage, you will only be able to convert to family coverage if you marry, have a child or adopt a child.

Anyone who elects COBRA continuation coverage must promptly notify Member Services of address changes.

Paying for COBRA coverage. If you, or your dependent(s), elect to continue coverage, you or they must pay the full cost of the coverage elected. The Fund is permitted to charge you the full cost of coverage for active employees and families, plus an additional 2% (and up to an additional 50% for the 11-month disability extension). The first payment is due no later than 45 days after the election to receive coverage (and it will cover the period from the date you would lose coverage until the date of payment). Thereafter, payments are due on the first of each month. If payment is not received on the first of the month, coverage will be terminated. However, if your payment is made within 30 days of the due date, coverage will be reinstated retroactive to the due date. Costs may change from year-to-year. Contact Member Services for more information about the cost of your COBRA coverage.

If you fail to notify Member Services of your decision to elect COBRA continuation coverage or if you fail to make the required payment, your Plan coverage will end (and cannot be reinstated).

What COBRA coverage provides. COBRA generally offers the same health coverage that is made available to similarly situated employees or family members; however, Life/AD&D and STD are not available. If, during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to COBRA recipients.

When COBRA coverage ends. COBRA coverage ordinarily ends after the maximum coverage period shown in the table on page 107. It will stop *before* the end of the maximum period under any of the following circumstances:

- A COBRA recipient fails to make the required COBRA contributions on time.
- A COBRA recipient becomes enrolled in Medicare (Part A, Part B or both) after the date of the COBRA election, or becomes covered under another group plan that does not have a pre-existing conditions clause that affects the COBRA recipient's coverage.[8]

[8] There are limitations on the Plan's imposing pre-existing condition exclusions, and such exclusions became prohibited in 2014.

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

If COBRA is terminated prior to the end of the original period, you will be notified.

Once your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Other Health Plan Information You Should Know

Assignment of Plan Benefits

To the extent permitted by law, your rights under this plan may not be voluntarily or involuntarily assigned, transferred or alienated. You cannot pledge the benefits owed to you for the purpose of obtaining a loan.

Rights under the Plan that cannot be assigned include your right to the services provided, the right to collect from the Plan for those services, the right to receive Plan documents and disclosures, the right to appeal benefits or claims determinations or the right to sue to enforce any such rights. However, the Plan reserves the right to pay all benefits due you to your health services provider and such payment shall extinguish any and all rights you may have under the Plan with respect to the services to which such payment relates.

Although as described above, you may not assign to a provider your right to file an appeal under the Plan's Appeals Procedures or to file a suit for benefits under Section 502(a) of ERISA, you may allow a provider to act as your authorized representative in an appeal under the Plan's Appeals Procedures.

Benefits or payments under the Plan are not otherwise assignable or transferable, except as the law requires. Benefits also are not subject to any creditor's claim or to legal process by any creditor of any covered individual, except under a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is an order issued by a state court or agency that requires an employee to provide coverage under group health plans to a child.

A QMCSO usually results from a divorce or legal separation. Whenever Member Services gets a QMCSO, its qualified status is carefully reviewed by the Fund in accordance with QMCSO procedures adopted by the Board and Federal law. For more information on QMCSOs, or to obtain a copy of the Plan's QMCSO procedures free of charge, contact the Fund's Compliance Office at the address on page 120.

No Liability for Practice of Medicine

Neither the Fund, the Board nor any of their designees:

- are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider, and
- will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Privacy of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a Federal law that imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Fund maintains about you, and knowing how your health information may be used. A complete description of how the Fund uses your health information, and your other rights under HIPAA's privacy rules is available in the Fund's "Notice of Privacy Practices", which is distributed to all named participants. Anyone may request an additional copy of this Notice by contacting the Compliance Office at the address on page 120.

The Fund's Board of Trustees adopted certain HIPAA privacy and security language that requires the Board of Trustees, in its role as Plan Sponsor of the Fund, to keep your health information private and secure. Any questions you may have about HIPAA may be directed to the Compliance Office at the address on page 120.

Converting to Individual Coverage

Life Insurance. After your group life insurance under the Plan ends, you may convert it to an individual life insurance policy, as long as you apply for converted coverage within:

- 31 days from the date benefits were terminated, or
- 45 days from the date notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated. (This time period is separate and apart from the Plan's COBRA provisions.)

You may convert your group coverage only to a Whole Life, Universal Life or One-Year Non-Renewable Term policy. The amount converted to an individual policy cannot be more than the amount you had under the group policy. The amount of your life insurance coverage is $15,000.

Your individual policy will become effective 61 days after the termination of your coverage. Group life insurance protection continues in force; however, during the applicable period cited above, whether or not you exercise the conversion option. Contact MetLife for more information about converting life insurance.

All Other Plan Benefits. You cannot convert hospital, medical, mental health and substance abuse, prescription drug, dental, vision, AD&D, or STD benefits to individual coverage.

General Information

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between employer associations or individual **employers** and your union. These collective bargaining agreements provide that **employers** contribute to the Fund on behalf of each covered employee. **Employers** that are parties to such collective bargaining agreements may also participate in the Fund on behalf of non-collectively bargained employees, if approved by the Trustees, by signing a participation agreement. Certain other **employers** (such as Local 32BJ itself) participate in the Fund on behalf of their employees by signing a participation agreement.

The Compliance Office will provide you, upon written request, with information as to whether a particular **employer** is contributing to the Fund on behalf of participants working under a collective bargaining agreement or participation agreement.

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in this booklet, but benefit payments also may be affected if you, your dependent, your beneficiary or your provider of services, as applicable, do not:

- file a claim for benefits properly or on time,
- furnish the information required to complete or verify a claim,
- have a current address on file with Member Services, and
- cash checks within 18 months of the date issued. The amounts of such uncashed checks will be restored to the Fund's assets and added to net assets available for benefits on the Fund's financial statements.

You should also be aware that Plan benefits are not payable for enrolled dependent(s) who become ineligible due to age, marriage, divorce or legal separation (unless they elect and pay for COBRA benefits, as described on pages 106–111).

If the Plan mistakenly pays more than you are eligible for, or pays benefits that were not authorized by the Plan, the Fund may seek any permissible remedy allowed by law to recover benefits paid in error. (Also see Subrogation and Reimbursement on pages 101–104 and Overpayments on page 104.)

Compliance with Federal Law

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

Plan Amendment or Termination

The Board intends to continue the Plan indefinitely, but reserves the right to amend or terminate it, in its sole discretion. If the Plan is terminated or otherwise amended, it will not affect your right to receive reimbursement for eligible expenses you have incurred prior to termination or amendment.

Upon a full termination of the Plan, Plan assets will be applied to provide benefits in accordance with the applicable provisions of the Trust Agreement and Federal law.

Keep in mind that the benefits provided under the Plan are not vested. This is true for retirees, as well as active employees. Therefore, at any time the Board can end or amend benefits, including retiree benefits, in its sole and absolute discretion.

Plan Administration

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

The Plan is administered by the Board of Trustees. The Board governs this Plan in accordance with an Agreement and Declaration of Trust. The Board and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan established under the Trust Agreement, and to decide all matters arising in connection with the operation or administration of the Plan established under the Trust. Without limiting the generality of the foregoing, the Board and/or its duly authorized designees shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan,
- formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan,

- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan,
- resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, as described in this SPD, the Trust Agreement or other Plan documents,
- process and approve or deny benefit claims and rule on any benefit exclusions, and
- determine the standard of proof required in any case.

All determinations and interpretations made by the Board and/or its duly authorized designee(s) shall be final and binding upon all participants, eligible dependent(s), beneficiaries and any other individuals claiming benefits under the Plan.

The Board has entered into an agreement with the Building Service 32BJ Health Fund to perform certain administrative functions. Most of your day-to-day questions can be answered by Member Services staff. If you wish to contact the Board, please write to:

Board of Trustees
32BJ North Health Fund
25 West 18th Street
New York, NY 10011-4676

Statement of Rights under the Employee Retirement Income Security Act of 1974 as Amended

As a participant in the 32BJ North Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Compliance Office, all documents governing the Plan, including insurance contracts, collective bargaining agreements, participation agreements and 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 Compliance Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, participation agreements, the latest annual report (Form 5500 series) and an updated SPD. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Board is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Coverage.

You may continue group health coverage for yourself, spouse or dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You, or your dependent(s), may have to pay for such coverage. Review this booklet (see pages 106–111 for information about COBRA) and the documents governing the Plan on the rules governing your COBRA continuation rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Pre-Existing Conditions Under the Plan

If you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.[9]

Prudent Action 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 welfare benefit or exercising your rights under ERISA.

[9]There are limitations on the Plan's imposing pre-existing condition exclusions, and such exclusions became prohibited in 2014.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 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 after you have exhausted the Plan's appeal process. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. You may not file a lawsuit until you have followed the appeal procedures described on pages 77–96. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of EBSA, U.S. Department of Labor, listed in your telephone directory, or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration ("EBSA")
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA or by visiting the Department of Labor's website: http://www.dol.gov or call their toll-free number at 1-866-444-3272.

Plan Facts

This SPD is the formal plan document for the Fund's Tri-State Preferred North Health Plan.

Plan Name: 32BJ North Health Fund
Employer Identification Number: 13-1699839
Plan Number: 501
Plan Year: January 1–December 31
Type of Plan: Welfare Plan

Funding of Benefits and Type of Administration

Self funded, except MetLife insures the Life and AD&D insurance benefits and, effective June 1, 2015, Guardian Life Insurance Company of America insures Short-Term Disability benefits. All contributions to the Trust Fund are made by **contributing employers** under the Plan in accordance with their written agreements. Benefits are administered by the organizations listed in the table on page 81.

Plan Sponsor and Administrator

The Plan is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees. The office of the Board may be contacted at:

Board of Trustees
32BJ North Health Fund
25 West 18th Street
New York, NY 10011-4676

Participating Employers

The Compliance Office will provide you, upon written request, with information as to whether a particular **employer** is contributing to the Plan on behalf of employees working under a written agreement, as well as the address of such **employer**. Additionally, a complete list of **employers** and unions sponsoring the Plan may be obtained upon written request to the Compliance Office and is available for examination at the Compliance Office.

To contact the Compliance Office, write to:

Compliance Office
32BJ North Benefit Funds
25 West 18th Street
New York, NY 10011-4676

To contact the Health Fund, call:

1-800-551-3225

or write to:

32BJ North Health Fund
25 West 18th Street
New York, NY 10011-4676

Agent for Service of Legal Process

The Board has been designated as the agent for the service of legal process. Legal process may be served at the Compliance Office or on the individual Trustees. For disputes arising under the portion of the Plan insured by MetLife, service of legal process may be made upon MetLife at their local offices or upon the supervisory official of the Insurance Department of the state in which you reside. For disputes under the portion of the Plan insured by Guardian, service of legal process may be made upon Guardian at:

Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004
Attention: General Counsel

or upon the supervisory official of the Insurance Department of the state in which you reside.

Glossary

Allowed amount means the maximum the Fund will pay for a covered service. When you go **in-network**, the **allowed amount** is based on an agreement with the provider. When you go **out-of-network**, the **allowed amount** is based on the Fund's payment rate of allowed charges to a **network** provider.

Ambulette means ground transportation to or from a licensed medical facility when arranged by the Plan's Medical Management Department. This is covered only as a home health care expense, meaning you need to be eligible for home health care in order to receive coverage for the **ambulette**.

Co-insurance means the 50% you pay toward eligible **out-of-network** medical expenses.

Contributing employer (or "**employer**") is a person, company or other employing entity that has signed a collective bargaining agreement or participation agreement with the union or trust, and the agreement requires contributions to the Health Fund for work in covered employment.

Co-payment means the flat-dollar fee you pay for office visits, hi-tech radiology, outpatient hospital visits, emergency room visits and hospital admissions and certain **covered services** (such as prescription drugs) when you use **participating providers**. The Plan then pays 100% of the remaining covered expenses.

Covered employment means work in a classification for which your **employer** is required to make contributions to the Fund.

Covered services are the services for which the Fund provides benefits under the terms of the Plan.

Deductible means the dollar amount you must pay each calendar year before benefits become payable for covered **out-of-network** services.

Doctor or **Physician** means a licensed and qualified provider (M.D., D.O., D.C. or D.P.M.) who is authorized to practice medicine, perform surgery and/or prescribe drugs under the laws of the state or jurisdiction where the services are rendered, acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Emergency means a condition whose symptoms are so serious that someone who is not a **doctor**, but who has average knowledge of health and medicine, could reasonably expect that, without immediate medical attention, the following would happen:

- the patient's health would be placed in serious jeopardy,
- there would be serious problems with the patient's body functions, organs or parts,
- there would be serious disfigurement, or
- the patient or those around him or her would be placed in serious jeopardy, in the event of a behavioral health **emergency**.

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

In-network benefits are benefits for **covered services** delivered by providers and suppliers who have contracted with the Fund, Empire, CVS Caremark or with any other administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services provided must fall within the scope of their individual professional licenses.

Medically necessary, as determined by the applicable third party administrator or the Fund, means services, supplies or equipment that satisfy all of the following criteria:

- are provided by a **doctor**, hospital or other provider of health services,
- are consistent with the symptoms or diagnosis and treatment of an illness or injury; or are preventive in nature, such as annual physical examinations, well-woman care, well-child care and immunizations, and are specified by the Plan as covered,
- are not experimental, except as specified otherwise in this booklet,
- meet the standards of good medical practice,
- meet the medical and surgical appropriateness requirements established under Empire BlueCross BlueShield medical policy guidelines,
- provide the most appropriate level and type of service that can be safely provided to the patient,
- are not solely for the convenience of the patient, the family or the provider, and
- are not primarily custodial.

The fact that a **network** provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it **medically necessary**.

Network means the same as **in-network**.

Out-of-network provider/supplier means a **doctor**, other professional provider or durable medical equipment, home health care or home infusion supplier who is not in the Plan's **network** for hospital, medical, mental health and substance abuse, dental, prescription drug or vision services.

Participating provider (or "**in-network provider**") means a provider that has agreed to provide services, treatment and supplies at a pre-negotiated rate under the hospital, medical, mental health and substance abuse, dental, prescription drug and vision plans.

TRICARE (formerly CHAMPUS) is the health services and support program for U.S. Military Personnel on active duty, U.S. Military retirees and their families.

Footnotes

1 ***Hospital/facility*** is 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, and
- an organized medical staff of licensed **doctors.**

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Empire or, for PPO participants, another BlueCross and/or BlueShield plan.

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

For kidney dialysis treatment, covered **in-network** only at facilities within the Empire **network**, a facility in New York State qualifies for **in-network benefits** if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another BlueCross and/or BlueShield plan. In other states, the facility must participate with another BlueCross and/or BlueShield plan and be certified by the state using criteria similar to New York's.

Blue Distinction Centers of Medical Excellence have demonstrated their commitment to quality care, resulting in overall better outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert **physicians**' and medical organizations' recommendations, including the Center for International Blood and Marrow Transplant Research, the Scientific Registry of Transplant Recipients and the Foundation for the Accreditation of Cellular Therapy and is subject to periodic re-evaluation as criteria continue to evolve. To qualify as a Blue Distinction Center of Medical Excellence for transplants, a facility must satisfy the BlueCross BlueShield Association's quality based selection criteria. Each facility responds to an Association survey which examines the facilities clinical structure, processes and outcomes for transplant services, as well as the facility's responses to the Standardized Transplant Administrative Survey for the United Network for Organ Sharing ("UNOS").

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

Empire does not recognize as hospitals: nursing or convalescent homes and institutions, rehabilitation facilities (except as noted above), institutions primarily for rest or for the aged, spas, sanitariums, infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or behavioral care.

2 ***Outpatient surgery*** includes hospital surgical facilities, surgeons and surgical assistants, chemotherapy and radiation therapy, including medications, in a hospital outpatient department, **doctor's** office or facility (medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy). Same-day, ambulatory or outpatient surgery (including invasive diagnostic procedures) means surgery that does not require an overnight stay in a hospital and:

- is performed in a same-day or hospital outpatient surgical facility,
- requires the use of both surgical operating and postoperative recovery rooms,
- does not require an inpatient hospital admission, and
- would justify an inpatient hospital admission in the absence of a same-day surgery program.

3 ***Kidney dialysis treatment*** (including hemodialysis and peritoneal dialysis) covered **in-network** only, is covered in the following settings until Medicare becomes primary for end-stage renal disease dialysis (which occurs after 30 months):

- at home, when provided, supervised and arranged by a **doctor** and the patient has registered with an approved kidney disease treatment center (not covered:

professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment), or

- in a hospital-based or freestanding facility.

4 ***Skilled nursing facility*** means a licensed institution (or a distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services. Skilled nursing facilities are useful when you do not need the level of care a hospital provides, but you are not well enough to recover at home. The Plan covers inpatient care in a skilled nursing facility, for up to 60 days of inpatient care per person per year. However, you must use an **in-network** facility and your **doctor** must provide a referral and a written treatment plan, a projected length of stay and an explanation of the needed services and the intended benefits of care. Care must be provided under the direct supervision of a **doctor**, registered nurse, physical therapist or other health care professional.

5 ***Hospice care*** is for patients who are diagnosed as terminally ill (that is, they have a life expectancy of six months or less). Hospice care is covered in full **in-network** only; there are no **out-of-network** hospice benefits. The Plan covers hospice services when the patient's **doctor** certifies that the patient is terminally ill and the hospice care is provided by a hospice organization certified by the state in which the hospice organization is located. Hospice care services include:

- up to 12 hours a day of intermittent nursing care by an RN or LPN,
- medical care by the hospice **doctor**,
- drugs and medications prescribed by the patient's **doctor** that are not experimental and are approved for use by the most recent "Physicians' Desk Reference",
- approved drugs and medications,
- physical, occupational, speech and respiratory therapy when required,
- lab tests, X-rays, chemotherapy and radiation therapy,
- social and counseling services for the patient's family, including bereavement counseling visits for up to one year following the patient's death (if eligible),
- **medically necessary** transportation between home and hospital or hospice,
- medical supplies and rental of durable medical equipment, and
- up to 14 hours of respite care a week.

6 ***Home health care*** means services and supplies, including nursing care by a registered nurse ("RN") or licensed practical nurse ("LPN") and home health aid services. The Plan covers up to 200 home health care visits per person per year (**in-network** only), as long as your **doctor** certifies that home health care is **medically necessary** and approves a written treatment plan. Up to four hours of care by an RN, a home health aide or a physical therapist count as one home health care visit. Benefits are payable for up to three visits a day. Home health care services include:

- part-time nursing care by an RN or LPN,
- part-time home health aid services,
- restorative physical, occupational or speech therapy,
- medications, medical equipment and medical supplies prescribed by a **doctor**,
- laboratory tests, and
- **ambulette** service when arranged by the Plan's Medical Management Department.

7 ***Home infusion therapy,*** a service sometimes provided during home health care visits is available only **in-network**. These services must be arranged for by your treating **physician**. An Empire POS **network** home health care agency or home infusion supplier may not bill you for **covered services**. If you receive a bill from one of these providers, contact Member Services.

8 ***Emergency room treatment benefits*** Remember to contact the Medical Management Department at the phone number on the back of your Empire ID Card within 48 hours after an **emergency** hospital admission, as described on pages 30–32, to pre-certify any continued stay in the hospital. If you have an **emergency** outside the Empire POS Operating Area (see page 29), show your Empire ID Card when visiting a local BlueCross BlueShield **participating provider**. If the hospital participates with another BlueCross and/or BlueShield program, your claim will be processed by the local BlueCross plan. If it is a non-participating hospital, you will need to file a claim in order to be reimbursed for your eligible expenses.

9 ***Ambulance services*** are covered in an **emergency** and in other situations when it is medically appropriate (such as taking a patient home when the patient has a major fracture or needs oxygen during the trip home). Air ambulance is covered when the patient's medical condition is such that the time needed to transport by land poses a threat to the patient's survival or seriously endangers the patient's health, or the patient's location is such that accessibility is only feasible by air transportation, and the patient is transported to the nearest hospital with appropriate facilities for treatment and there is a medical condition that is life threatening. Life threatening medical conditions include, but are not limited to, the following:

- Intracranial bleeding,
- Cardiogenic shock,
- Major burns requiring immediate treatment in a Burn Center,
- Conditions requiring immediate treatment in a Hyberbaric Oxygen Unit,
- Multiple severe injuries,
- Transplants,
- Limb-threatening trauma,
- High risk pregnancy, and
- Acute myocardial infarction, if this would enable the patient to receive a more timely **medically necessary** intervention (such as PTCA or fibrinolytic therapy). Pre-certification of air ambulance is required in non-emergency situations.

10 ***Diabetes coverage*** includes diet information, management and supplies (such as blood glucose monitors, testing strips and syringes) prescribed by an authorized provider.

11 ***Preventive care*** services fall into four areas:

- evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force ("USPSTF"),
- immunizations for routine use in children, adolescents, or adults recommended by the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*,
- evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents, and
- other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Some of the preventive care services that are covered are listed in the Schedule of Covered Services on pages 34–47. The Plan covers certain preventive care services without imposing any **co-payments** when using an **in-network provider**.

The list of preventive care services may change. You may find a list of preventive care services at http://www.hhs.gov or by contacting Member Services at 1-800-551-3225.

12 ***Well-child care*** covers visits to a pediatrician, family practice **doctor**, nurse or a licensed nurse practitioner. Regular checkups may include a physical examination, medical history review, developmental assessment, guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory and must be within five days of the **doctor's** office visit. The number of well-child visits covered per year depends on your child's age, as shown in the table on pages 41–42. Covered immunizations include: Diphtheria, Tetanus and Pertussis ("DtaP"), Hepatitis B, Haemophilus influenza Type B ("Hib"), Pneumococcus ("Pcv"), Polio ("IPV"), Measles, Mumps and Rubella ("MMR"), Varicella ("chicken pox"), Tetanus-diphtheria ("Td"), Hepatitis A & influenza, HPV, Rotavirus, Meningococcal – polysaccharide and conjugate, other immunizations as determined by the American Academy of Pediatrics, Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.

13 ***Services of a certified nurse-midwife*** are covered if she or he is affiliated with, or practicing in conjunction with, a licensed facility and the services are provided under qualified medical direction.

14 ***Pre-planned home delivery of a child by a certified nurse-midwife*** is a covered service. The reimbursement rate for this service is at the contracted Empire POS Obstetrician/Gynecologist global rate.

15 ***Physical therapy*** is covered for up to 30 days of covered inpatient physical therapy per person per year (**in-network** and **out-of-network** combined). Physical therapy, physical medicine and rehabilitation services, or any combination of these, are covered as long as the treatment is prescribed by your **doctor** and designed to improve or restore physical functioning within a reasonable period of time. If you receive therapy on an inpatient basis, it must be short-term. Occupational, speech and vision therapy are covered if prescribed by your **doctor** and provided by a licensed therapist (occupational, speech or vision, as applicable) in your home, in a therapist's office or in an approved outpatient facility.

Up to 30 outpatient visits are covered per year for physical therapy. Speech, vision and occupational therapy combined are covered for up to 30 visits per year. You must receive any such services only through a **network** provider in the home, office or the outpatient department of a **network** facility. For outpatient physical therapy, your participating therapist will pre-certify services required after your first assessment visit.

16 ***Durable medical equipment and supplies*** means buying, renting and/or repairing prosthetics (such as artificial limbs), orthotics and other durable medical equipment and supplies, but you must go **in-network** for them. In addition to the items listed above, the Plan covers:

- prosthetics/orthotics and durable medical equipment from suppliers, when prescribed by a **doctor** and approved by Empire including:

– artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses,

– supportive devices essential to the use of an artificial limb,

– corrective braces,

– wheelchairs, hospital-type beds, oxygen equipment and sleep apnea monitors,

– replacement of covered medical equipment because of wear, damage, growth or change in the patient's need when ordered by a **doctor,** and

– reasonable cost of repairs and maintenance for covered medical equipment. The **network** supplier must pre-certify the rental or purchase of durable medical equipment. In addition, the Plan will cover the cost of buying equipment when the purchase price is expected to be less costly than long-term rental, or when the item is not available on a rental basis.

17 ***Nutritional supplements*** include enteral formulas, which are covered if the patient has a written order from a **doctor** that states the formula is **medically necessary** and effective, and that without it the patient would become malnourished, suffer from serious physical disorders or die. Modified solid food products will be covered for the treatment of certain inherited diseases if the patient has a written order from a **doctor**.

18 ***Cosmetic surgery*** will be considered not **medically necessary** unless it is necessitated by injury, is for breast reconstruction after cancer surgery or is necessary to lessen a disfiguring disease or a deformity arising from, or directly related to, a congenital abnormality. *Cosmetic treatment* includes any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

19 ***Experimental or "investigative"*** means treatment that, for the particular diagnosis or treatment of the enrolled person's condition, is not of proven benefit and not generally recognized by the medical community (as reflected in published literature). Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of an enrolled person's condition. A claims administrator may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

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

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Contact Information

What do you need?	Who to contact	How
• General information about your eligibility and benefits • Information on your hospital, medical, vision, dental and disability benefits and claims	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday, or Visit the Welcome Center at 25 West 18th Street New York, NY 8:30 am–6:00 pm Monday–Friday
• To find a 5 Star Center • To find a primary care **physician** • To find participating Empire BlueCross BlueShield providers	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday or Visit www.32bjfunds.org
• To find a participating dental plan provider	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday, or Dental: Visit www.asonet.com
• To find a participating vision plan provider	Davis Vision	Call 1-800-999-5431 8:00 am–11:00 pm, Monday–Friday Saturday, 9:00 am–4:00 pm Sunday, 12:00 pm–4:00 pm Visit www.32bjfunds.org
• Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com
• To pre-certify a hospital or medical stay	Empire BlueCross BlueShield	Providers call 1-800-982-8089
• To pre-certify mental health or substance abuse stay	Empire BlueCross BlueShield	Providers call 1-855-531-6011
• To help prevent or report health insurance fraud (hospital or medical)	Empire Fraud Hotline	Call 1-800-423-7283 9:00 am–5:00 pm, Monday–Friday
• Information about your prescription drug benefits, formulary listing or participating pharmacy	CVS Caremark	Call 1-877-765-6294 or Visit www.Caremark.com 24 hours a day/7 days a week
• Immediate medical advice	Nurses Healthline	Call 1-877-825-5276 24 hours a day/7 days a week
• Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc.	Empire BlueCross BlueShield	Call 1-212-388-3660

32BJ North Health Fund
25 West 18th Street
New York, NY 10011-4676

www.32bjfunds.org
800-551-3225 Benefits Information

Kyle Bragg, *Chairman*
William Schur, *Secretary*
Richard W. Berger
Manny Pastreich

32BJ NORTH HEALTH FUND
SUMMARY OF MATERIAL MODIFICATIONS

PLAN NAME: 32BJ North Health Fund, Tri-State Preferred North Plan (Plan)

DATE: September 27, 2017

This Summary of Material Modifications (SMM) supplements or modifies the information presented in your Summary Plan Description (SPD) dated January 1, 2015 with respect to the Plan. **Please keep this document with your copy of the SPD for future reference.**

Change in Fund Auditor's Name: Page 1: Effective August 31, 2017, Bond Beebe has joined Withum Smith & Brown, PC and changed its name to Withum Smith & Brown PC

Clarification in Coverage of Allergy Visits Page 11: The last sentence in the answer to FAQ 10 is deleted and replaced with the following sentence:

For example, treatment for allergy care is covered up to 12 treatment visits per calendar year, plus up to two testing visits per calendar year. (See pages 34–47 for all services with visit limits.)

Clarification on Cancelation of Coverage When Eligible for Medicare Page 16: the following new bullet is added after the second bullet in the list under the section *When You Are No Longer Eligible*:

- on the date you cancel your coverage with the Fund because you are eligible for Medicare,

Change in Dependent Eligibility: Chart pages 19-20: Effective February 1, 2016, the chart under the section "Dependent Eligibility" is deleted in its entirety and replaced with the following chart:

Dependency	Age Limitation	Requirements
Spouse	None	The person to whom you are legally married (if you are legally separated or divorced, your spouse is not covered).
Children	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child is one of the following: • Your biological child, • Your adopted* child or one placed with you in anticipation of adoption, or • Your stepchild: this includes your spouse's biological or adopted child.
Children (dependent) –Your grandchild, niece or nephew ONLY if you are the legal guardian*** (if application for legal guardianship is pending, you must provide documentation that papers are filed and provide proof when legal process is complete)	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child: • Is not married, • Has the same principal address as the participant**, or as required under the terms of a "QMCSO" (see page 81), and • Is dependent on the participant for all of his or her annual support and maintenance and is claimed as a dependent on your tax return**.

Note that the section "Children (disabled) over age 26 was deleted in its entirety.

Addition of Explanation of Annual Out-of-Pocket Maximum on In-network Benefits Page 23: The section "Annual Out-of-Pocket Maximum on In-Network Hospital, Medical, Mental Health, Substance Abuse and Pharmacy Benefits" is deleted in its entirety and replaced with the following:

Annual Out-Of-Pocket Maximum on In-Network Hospital, Medical, Mental/Behavioral Health and Substance Abuse Benefits and Pharmacy Benefits

Annual out-of-pocket maximum on in-network benefits. There is an annual out-of-pocket maximum on **in-network** hospital, medical, mental health and substance abuse and pharmacy benefits. Your annual out-of-pocket maximum is $7,150 and your family's annual out-of-pocket maximum is $14,300.* If you have other family members enrolled in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

The annual out-of-pocket maximum is divided between medical and prescription drug benefits.

Your annual out-of-pocket maximum for **in-network** medical benefits is $5,400 and your family's annual out-of-pocket maximum for **in-network** medical benefits is $10,800. After a family has spent $10,800 in out-of-pocket costs for **in-network** medical benefits, regardless of how much each family member paid in out-of-pocket costs for **in-network** medical benefits, there are no additional out-of-pocket costs for any additional **in-network** medical benefits during the calendar year.

Your annual out-of-pocket maximum for **in-network** prescription drug benefits is $1,750 and your family's annual out-of-pocket maximum for **in-network** prescription drug benefits is $3,500. After a family has spent $3,500 in out-of-pocket costs for **in-network** prescription drugs, regardless of how much each family member paid in out-of-pocket costs for **in-network** prescription drugs, there are no additional out-of-pocket costs for any additional **in-network** prescription drugs during the calendar year.

Expenses that apply toward the annual out-of-pocket maximum:

• **Co-payments**,
• **Deductibles**, and
• **Co-insurance**.

Expenses that do not count toward the annual out-of-pocket maximum. The following expenses are not applied toward the **in-network** annual out-of-pocket maximum:

• Premiums,
• Balance billing, and
• Spending for non-covered services.

*The Department of Health and Human Services (HHS) examines the limits annually and may increase them based on the premium adjustment percentage (an estimate of the average change in health insurance premiums). The Plan will change its out-of-pocket maximums each January 1 to match HHS' limits.

Addition of TeleMedicine Page 25: Effective April 1, 2016, the following new paragraph is added at the end of the section "Conditions for Hospital and Medical Expense Reimbursement":

LiveHealth Online.
LiveHealth Online is a convenient way to have a face to face interaction online with a doctor when you need care but can't reach your regular doctor after hours, on holidays or on weekends. LiveHealth Online should be used for non-urgent medical situations like colds, sore throats, or the flu. LiveHealth Online from Empire BlueCross BlueShield is available 24/7 and effective January 1, 2018 there is a $40 co-pay for this service. The online doctor can diagnose, treat and, if state regulations allow, prescribe medications.

Download the LiveHealth Online app on a computer, tablet or smart phone and follow the instructions.

Addition of Telephone Number for Member to Call to Get An Estimate of What it Would Cost to Use a Non-Participating Provider Page 29: Immediately preceding the section "Coverage When You Are Away From Home" the following is added:

If you are thinking about using a non-participating provider and would like to get an idea of how much you will have to pay, call Empire at 1-866-316-3394. In order to assist you, Empire will need to know the non-participating provider's office location (city and state) where you will be seen and the CPT code for the procedure you will have. You must get the CPT code from the non-participating provider.

Addition of Services Requiring Pre-certification Page 31: The following services are added to the chart on page 34 in the column *Type of Care* under Outpatient:

- Sleep studies
- Percutaneous Coronary Intervention (PCI), Cardiac Catheterization and Vascular Ultrasound

Reduction in Mental Health and Substance Abuse In-network Co-payments Pages 10 (FAQ 5), 26, 32 and 40: Effective January 1, 2017, the co-payment for in-network out-patient office visits for mental health or substance abuse treatment is reduced from $40/ visit to $20/visit.

Addition of Exclusion on Non-participating Substance Abuse Providers Pages 33 and 40: Effective January 1, 2017, the sentence below is added to the Non-Participating Hospital or Facility Expense Column for Hospital inpatient and Hospital outpatient department visits on page 33 and to the Limitations column for all Substance Abuse care (inpatient substance abuse, physician office visits and outpatient hospital facility) on page 40:

The Fund will not cover any treatment with non-participating inpatient and outpatient substance abuse providers in New York, unless the provider is certified and/or licensed by the Office of Alcoholism and Substance Abuse Services. The Fund will also not cover any treatment by non-participating providers in any other state unless the provider is certified by a similar state agency and accredited by The Joint Commission.

Addition of Total Joint Replacement Program Page 35: Effective July 1, 2016, the following row is added after Transplant surgery and before Skilled nursing care facility to the In the Hospital[1] and other Inpatient Treatment Centers section of the Schedule of Covered Services chart:

Benefit	In-Network	Out-of-Network	Limitations
Total Joint Replacement (hip and knee)*	Plan pays 100% if surgery is conducted at a facility that is part of the Mount Sinai Health System (MSHS) hospital network in New York City. For surgery at another in-network facility, Plan pays up to 100% of the **allowed amount** that it would have paid MSHS facility. Member responsible for the difference in cost up to the annual in-network out-of-pocket maximum.	Plan pays 50% of the **allowed amount** after the **deductible**.	Call Member Services for information about the 32BJ Joint Replacement Program

Addition of Gender Reassignment Surgery Page 35: The following row is added after Total Joint Replacement (hip and knee) and before Skilled nursing care facility to the In the Hospital[1] and other Inpatient Treatment Centers section of the Schedule of Covered Services chart:

Benefit	In-Network	Out-of-Network	Limitations
Gender Reassignment Surgery	Plan pays 100%	Plan pays 50% of the **allowed amount** after the **deductible**.	

Clarification of Costs for Using Out-of-network Providers in an Emergency and Ambulance Service Limitations Page 36: The chart on page 36, Emergency Care, is deleted in its entirety and replaced with the following chart:

Emergency Care

Benefit	In-Network	Out-of-Network	Limitations
Emergency room[8] ("ER") in a hospital	Plan pays 100%* after $100 **co-payment** for 1st two visits; then $200 **co-payment** per visit		ER co-payment increases after the 2nd ER visit in a calendar year. Follow–up visits to the ER are not covered.
Urgent care center	Plan pays 100% after $40 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**.	
Ambulance service[9]	Plan pays 100%		Not covered if after transport you do not receive treating services.

See footnotes 8 and 9 on page 134.
* In an emergency, if you use **out-of-network** providers you may be responsible for **deductibles** and **co-insurance** and you may be balance billed if the **out-of-network** provider's charges exceed the **allowed amount**.

Elimination of the $75 Co-payment for Blood Work Performed in a Hospital Outpatient Setting Page 37: Effective January 1, 2017, the following two sentences are added at the end of the paragraph in the first row of the Limitations column:

Note: There is no co-payment for blood tests done in an in-network hospital outpatient setting. And, the co-payment for services received at a hospital clinic is $40 per visit.

Addition of Hyperbaric Oxygen Treatment Page 37: The following row is added after Chemotherapy and before Kidney dialysis to the Outpatient Treatment Facilities section of the Schedule of Covered Services chart:

Benefit	In-Network	Out-of-Network	Limitations
Hyperbaric Oxygen Treatment*	Plan pays 100% after **co-payment** based on the setting in which the service is provided: If in outpatient hospital setting – $75 **co-payment** If in freestanding surgical facility – $0 **co-payment**	Plan pays 50% of the **allowed amount** after the **deductible**.	When services are received in a hospital outpatient setting, there is a $75 **co-payment** per visit with the exception of chemotherapy, radiation therapy and hyperbaric oxygen treatment which have one $75 **co-payment** per calendar year. Note: There is no **co-payment** for blood tests done in an **in-network** hospital outpatient setting.

Clarification in Coverage of Allergy Visits Page 38: In the Care in the Doctor's Office chart, the Allergy Care Limitation is deleted and replaced with the following:

Limited to 12 treatment visits per calendar year, plus up to two testing visits per calendar year for allergy care.

Clarification of Family Planning Services Benefits Page 43: The chart under Family Planning services is deleted and replaced in its entirety with the following chart:

<table>
<tr><th>Benefit</th><th>In-Network</th><th>Out-of-Network</th><th>Limitations</th></tr>
<tr><td>Family planning office visits and counseling for contraceptive measures and devices (such as tubal ligation, IUD insertion and diaphragm fittings)</td><td>No co-payment.

Plan pays 100%</td><td rowspan="4">Plan pays 50% of the allowed amount after the deductible</td><td></td></tr>
<tr><td>Vasectomy (excludes reversals)</td><td rowspan="3">Plan pays 100% after co-payment. See Overview of Out-of-Pocket Expenses on pages 32-33.)</td><td rowspan="2">The type of facility where service is provided will determine co-payment.</td></tr>
<tr><td>Abortion includes elective and non-elective procedures</td></tr>
<tr><td>Infertility Testing</td><td>Infertility testing limited to once per calendar year</td></tr>
<tr><td>Infertility treatment</td><td>Not Covered</td><td>Not Covered</td><td>No coverage for services upon the diagnosis of infertility.</td></tr>
</table>

Addition of Coordination of Benefits Provision when Dental Benefits are Covered under both the Medical and Dental Portions of the Plan Page 47: The following sentence is added to the text in the * which follows the Dental Care chart:

When a dental procedure is eligible for coverage under both your hospital/ medical plan and dental plan, your hospital/medical plan will always be the primary payor.

Elimination of Existing Exclusion Page 48: Effective January 1, 2016 the 7th bullet ("surgery and/or non-surgical treatment for gender change" under the section "Excluded Hospital, Medical, Mental Health and Substance Abuse Expenses") is deleted in its entirety.

Clarifications Regarding Specialty Drugs and How and Where to Obtain Them Pages 55 and 57: The sections "Specialty Drugs" and "Through CVS Caremark Specialty Pharmacy Program" are deleted in their entirety and replaced with the following:

Specialty Drugs

Under your CVS Caremark plan, specialty drugs are high cost prescription medications used to treat rare, complex or chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Although sometimes these medications are taken orally, they often require special handling such as refrigeration during shipping and storage, and administration through injection or infusion. They also often require customized patient monitoring, coordination of care and adherence management.

Your pharmacy benefits cover only specialty drugs on the CVS Caremark formulary that are filled either at a CVS retail pharmacy or through the CVS Caremark Specialty Pharmacy. There is no coverage for specialty drugs that are not included in the CVS Caremark formulary. And there is no coverage for formulary specialty drugs that are not filled either at a CVS retail pharmacy or through the CVS Caremark Specialty Pharmacy.

The **co-payment** for specialty drugs is the same as described in the table on page 58.

For Specialty Drugs
If you need a formulary specialty drug, there are two ways you can fill your prescription:
1. At a CVS retail pharmacy, or
2. Through the CVS Caremark Specialty Pharmacy Program.

If you do not use one of these two methods to fill your formulary specialty drug, there is no coverage and you will be responsible for the entire cost.

At a CVS Retail Pharmacy
You can get your formulary specialty medication at any CVS retail pharmacy. Just go to any CVS retail pharmacy and present your prescription and CVS Caremark ID. All prescriptions filled at a CVS retail pharmacy provide you with up to a 90-day supply.

Through CVS Caremark Specialty Pharmacy Program
You can use the CVS Caremark Specialty Pharmacy Program by calling 1-800-237-2767. A CVS Caremark service representative will assist you in completing the specialty drug registration process.

Note: The Specialty Pharmacy will send your 90 day prescription order in three separate deliveries of 30 day fills over the course of the 90 days. With each 30 day fill that the Specialty Pharmacy sends, it will charge you 1/3 of the **co-payment** required.

Addition of a Description of the Prescription Plan Coverage Management Programs: On page 57, the fifth paragraph (which continues on to page 58) is deleted in its entirety and after the section "For Specialty Drugs" a new section "Prescription Plan Coverage Management Programs" is added:

Prescription Plan Coverage Management Programs

The prescription plan uses coverage management programs to help ensure you receive the prescription drugs you need in the appropriate quantity and at a reasonable cost. Coverage management programs include prior authorization, quantity limitations and step therapy. Each of these programs is described in detail below and on the next page.

Prior Authorization
Certain medications require prior authorization before your prescription will be covered under the Plan. The Prior Authorization Program is administered by CVS Caremark to determine whether your use of certain medications meets your plan's conditions of coverage and CVS Caremark's clinical guidelines for use of the specific drug. The prescriber will need to contact CVS Caremark's Prior Authorization Department to provide the necessary clinical information to determine the appropriateness of the medication for the member before the prescription can be filled.

Quantity Limitations
Quantity limits are provisions in the prescription benefit that are designed to make the use of prescription drugs safer and more affordable. It provides you with medications you need for your good health while making sure you receive them in a quantity considered safe and clinically appropriate. For medications with quantity limitations, you can receive an amount to last you a certain number of days; for instance, the program could provide a maximum of 30 pills for a medication you take once a day. This is considered an acceptable amount to take the daily dose considered safe and effective, according to guidelines from the Food and Drug Administration ("the FDA") and product dosing guidelines. Some medications may have a quantity limit with a post-limit prior authorization, meaning if you require more than the initial quantity limit, your **doctor**/prescriber must provide medical necessity information as to why you require more of the medication.

Step Therapy
Step therapy is a program which will help to ensure that the medications you receive are safe and cost-effective. Step therapy may first require the use of generic or alternate brand medications. When you present a prescription for certain medications to your pharmacist, CVS Caremark will check to see if you've tried a generic or alternate medication to treat the same condition. If your prescription history shows use of generic or alternate brand option, the targeted prescription may be approved and filled. If there is no history of a generic or alternate brand medication use, the pharmacist will receive a message for the prescriber to call a toll free number for more information. The prescriber will be asked to prescribe a generic alternative first before moving to the single source brand medication. In the event that the prescriber advises CVS Caremark that a generic or alternate brand medication is not right for the member, the prescriber can then call the CVS Caremark Prior Authorization Department to seek approval for the single source brand medication.

Your pharmacist can tell you if the prescription drug order you need to have filled requires prior authorization or is subject to quantity limitations or step therapy. Contact CVS Caremark at 1-877-765-6294 before having the prescription filled to ensure that you receive the maximum coverage for the prescription you are given. If you have a prescription filled for a drug that is on the list of those requiring prior authorization or is subject to quantity management or step therapy and you fail to contact CVS Caremark before having the prescription filled, you may be responsible for the full cost of the prescription drug.

Clarifications in Vision Benefits Page 70: The fourth paragraph under the section "Vision Care Benefits" is deleted in its entirety and replaced with the following:

> If you get contact lenses instead of frames and lenses, from either a participating or non-participating provider, the contact lens exam fitting fee is not covered and the maximum reimbursement for the contact lenses is $120.
>
> If you use a participating provider, your eye exam is free. If you use a non-participating provider, you can get up to $30 for your eye exam. You will be responsible for paying any charges in excess of the maximum reimbursement.

Page 71: Under the section "Eligible Expenses", a new bullet is added after the second bullet:

- and frames.

Under the section "Excluded Expenses", a new bullet is added after the second bullet:

- exam fitting fees for contact lenses,

Clarification on Cancelation of Coverage When Eligible for Medicare Page 73: The following sentence is added after the first sentence in the paragraph under the section *When Coverage Ends*:

Life insurance also ends if you cancel your coverage under this Plan due to Medicare eligibility. (See page 99.)

Clarification on Cancelation of Coverage When Eligible for Medicare and 75: The following sentence is added after the sentence under the section *When Coverage Ends*:

AD&D also ends if you cancel your coverage under this Plan due to Medicare eligibility. (See page 99.)

Clarification in Coordination of Benefits with Medicare and Cancelation of Coverage Due to Medicare Eligibility Page 99: Under the first bullet in the section "Medicare", the following sentence is added at the end of the bullet:

If you cancel your coverage under this Plan, you cannot elect back into this Plan. Additionally, if you cancel your coverage under this Plan, the Plan will not be allowed to offer you any benefits that would supplement Medicare's benefits. When you cancel coverage under this Plan all benefits end including medical, hospital, mental health and substance abuse, prescription drug, dental, vision and Life Insurance & Accidental Death and Dismemberment.

Addition of Language to Assist in Recovery of Benefits Amounts Subject to a Subrogation Pages 101-104: Effective October 1, 2016, throughout the section titled **Subrogation and Reimbursement** wherever the word "lien" appears, the following phrase will be added immediately thereafter "and/or an equitable lien by agreement".

Page 102: the following is added to the end of the first bullet:

- refusal by you and/or your dependent(s) to reimburse the Fund will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund, and you and/or your dependent(s) affirmatively waive any defenses you may have in any action by the Fund to recover amounts due, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible, under applicable law,

In addition, in the second bullet where the term "constructive trust" appears the phrase ", lien and/or equitable lien by agreement" is added immediately following that term.

Addition of Language to Assist in Recovery of Overpayments Page 104: Effective October 1, 2016, the following two paragraphs are added after the last bullet under the **Overpayments** section:

> The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid benefits received by you or your Dependents or a representative of you or your Dependents (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your Dependents for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your Dependents consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you, and your Dependents agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.
>
> Any refusal by you or your Dependents to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependents affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Clarification of Payment Responsibility when Medicare is Primary and Health Fund is Secondary Page 110: Before the first full paragraph the following paragraph is added:

If you are age 65 or older when you incur a Qualifying Event that requires an offer of COBRA coverage to you and your dependents, Medicare will be primary and this Plan will be secondary for you and any of your dependents who are age 65 or older. If you do not enroll in both Medicare Part A and Part B coverage, even though this Plan pays as secondary, you will be financially responsible for what Medicare would have paid had you properly enrolled.

Modification of Assignment of Plan Benefits Page 111: The following is added to the end of the second paragraph under the section "Assignment of Plan Benefits":

In order to appoint a provider as your authorized representative, you must submit a legibly signed authorization with your appeal that includes:

- Your name,
- Your identification number as shown on your Empire, CVS/Caremark, Delta Dental or Davis Vision card, as applicable,
- Your date of birth,
- Your address,
- The full name of the party whom you are authorizing to act on your behalf,
- The date(s) for which the authorization applies, and
- A sentence which clearly states that the party is authorized to file an appeal on your behalf.

Clarification in the Definition of Allowed Amount Glossary: The definition of **Allowed Amount** on page 121 is deleted in its entirety and replaced with the following:

Allowed Amount means the maximum the Fund will pay for a covered service. When you go **in-network**, the **allowed amount** is the amount Empire and the network provider have contractually agreed upon. When you go **out-of-network**, the **allowed amount** is roughly equivalent to 110% of the Medicare reimbursement rate but varies depending on the procedure. It is not the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service, commonly referred to as the usual, customary and reasonable ("UCR") rate.

Page 11: The above paragraph is also added after the last sentence in the answer to FAQ 9.

Change in Davis Vision Website Address Back Cover: In the chart, the website information for Davis Vision is deleted and replaced with: www.davisvision.com/32bj

Adoption of New Dental Plan Pages 60-69: Effective January 1, 2017, pages 60-69 are deleted in their entirety and replaced with the following:

Dental Benefits

How the Plan Works

The Plan provides coverage for necessary dental care received through:

- a Delta Dental NY Select participating dentist or
- a non- participating dentist.

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

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

Participating Dental Providers

The Dental Plan's dental benefits include a "participating dental provider" feature through Delta Dental. The Delta Dental NY Select network is the Plan's participating dental provider **network**. Dentists who participate in the Delta Dental NY Select network have agreed to accept, as payment in full, the NY Select Allowance for all covered dental services.

If you choose to receive your care from a participating NY Select dental provider, you will not have to pay anything for covered dental care that you receive except for:

- major services, such as fixed bridgework, crowns and dentures, for which you will have a $75 **co-payment** per service,
- orthodontic services for dependents under 19 years of age, which will be covered at 100% for up to a $2,500 lifetime benefit maximum. You are responsible for charges in excess of $2,500, up to Delta Dental's allowed amount for a NY Select participating dentist.

Non-Participating Dental Providers

The Plan will pay for dental work performed by any properly accredited dentist, but the Plan will pay no more than 50% of what Delta Dental would have paid a participating Delta Dental NY Select dentist for that service. Your non-participating dentist can obtain Delta Dental's reimbursement allowance by submitting a Pre-Determination request directly to Delta Dental before you begin any dental work.

You will be required to pay the dentist's full charges. You will file a claim with Delta Dental and will be reimbursed according to the Delta Dental NY Select fee schedule for each procedure.

The Fund will pay the lesser of the dentist's actual charge for a covered dental service or 50% of the **allowed amount** for that procedure according to Delta Dental's NYSelect fee schedule. You will be responsible for the other 50%. In addition, amounts above the **allowed amount** are not eligible for reimbursement and are your responsibility to pay.

Predeterminations/Pretreatment Estimates

Determine costs ahead of time by asking your Delta Dental participating dentist to submit the treatment plan to Delta Dental for a predetermination of benefits before any treatment is provided. Delta Dental will verify your specific plan coverage and the cost of the treatment and provide an estimate of your copayments, if any, and what Delta Dental will pay. Predeterminations are free and help you and your dentist make informed decisions about the cost of your treatment.

Covered services are listed in the Schedule of Covered Dental Services for The Delta Dental NYSelect Plan, subject to frequency limitations that are stated in that Schedule. The Plan pays no benefits for procedures that are not in that Schedule, but may provide an alternate benefit if approved by Delta Dental of New York, Inc. ("Delta Dental") on behalf of the Fund. Whether you have to pay for those services and, if so, how much, depends on whether you choose to receive your dental care from a Delta Dental participating NY-Select dental provider or a non- participating dentist.

What Dental Services Are Covered

The Delta Dental Plan covers a wide range of dental services, including:

- Preventive and diagnostic services, such as routine oral exams, cleanings, X-rays, topical fluoride applications, space maintainers and sealants.
- Basic therapeutic services, such as extractions and oral surgery, intravenous conscious sedation when **medically necessary** for oral surgery, gum treatment, gum surgery, fillings and root canal therapy.
- Major services, such as fixed bridgework, crowns and dentures. These are subject to a $75 **co-payment** per service.
- Orthodontic services for children under 19, such as diagnostic procedures and appliances to realign teeth. There is a separate lifetime maximum on orthodontic services of $2,500 per patient.

See the Schedule of Covered Dental Services for the Fund's Dental plan for details.

Annual Maximum

The Dental Plan provides coverage of up to $2,000 per participant/dependent age 19 and older per calendar year. There is no annual maximum for participants and dependent(s) under 19 years of age. There is a separate lifetime maximum of up to $2,500 for orthodontic services for children under 19 years of age.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services for the Dental Plan on the following pages:

Procedure	Limits
Diagnostic	
Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused)	Two in a calendar year
X-rays:	
• full mouth, complete series, including bitewings or panoramic film	Once in a 36 consecutive month period
• bitewings, back teeth	Two of any bitewing x-ray procedure in a calendar year.
• periapicals, single tooth	As necessary
• occlusal film	Two per date-of-service
• cephalometric film (orthodontic coverage only)	Once in a lifetime
Preventive	
Dental prophylaxis (cleaning, scaling and polishing)	Two in a calendar year
Topical fluoride treatment	Two in any calendar year for patients under age 16
Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)	Once per tooth in any 24 consecutive month period for patients under age 16
Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)	Once in a lifetime per tooth for patients under age 16
Simple Restorative	
Amalgam (metal) fillings	Once per tooth surface in any 24 consecutive months
Resin (composite, tooth-colored) fillings on anterior teeth	Once per tooth surface in any 24 consecutive months

Schedule of Covered Dental Services Delta Dental NY Select (continued)

Procedure	Limits
Major Restorative	
Recementation of crown	Once per lifetime per tooth /$75 **co-payment**
Prefabricated stainless steel/resin crown* (for children only-deciduous teeth only)	Once per tooth in any 24 consecutive months/$75 **co-payment**
Inlays, Onlays, and Crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture	Once per tooth in any 60 consecutive month period/$75 **co-payment**
Endodontics	
Root canal therapy	Once per tooth in a lifetime
Retreatment of root canal	Once per tooth in a lifetime
Apicoectomy (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment)	Once per tooth in a lifetime
Pulpotomy	Once per tooth in a lifetime
Periodontics	
Gingivectomy or gingivoplasty	Once per quadrant in a 60 consecutive month period
Osseous surgery	Once per quadrant in a 60 consecutive month period
Periodontal scaling and root planing	Once per quadrant within a 24-month period
Periodontal maintenance (covered only if the Plan also covered periodontal surgery and the maintenance procedure is performed by a periodontist)	Two of any prophylaxis procedure in a calendar year

Schedule of Covered Dental Services Delta Dental NY Select (continued)

Procedure	Limits
Removable Prosthodontics	
Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care	One denture per arch in any 60 consecutive month period
Denture rebase or reline procedures, including six months of routine post-delivery care	Once per appliance in any 36 consecutive month period
Interim maxillary and mandibular partial denture (anterior teeth only); no other temporary or transitional denture is covered by the Delta Dental Plan	Once per appliance in any 60 consecutive month period
Fixed Prosthodontics	
Fixed partial dentures and individual crowns	Once per tooth in any 60 consecutive month period
Prefabricated post and core procedures related to fixed partial denture (X-ray showing completed endodontic procedure is required)	Once per tooth in any 60 consecutive month period
Simple Extractions	
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Once per tooth in a lifetime
Oral and Maxillofacial Surgery	
Removal of impacted tooth*	Once per tooth in a lifetime
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)	Once per quadrant in a lifetime
Frenulectomy	Once per arch in a lifetime
Removal of exostosis (removal of overgrowth of bone)	Once per site in a lifetime
Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm and incision and drainage of an intraoral or extraoral abscess.	
Emergency Treatment	
Palliative treatment to alleviate immediate discomfort (minor procedure only)	Once per date-of-service

Procedure	Limits
Repairs	
Temporary crown (fractured tooth)	One crown procedure per tooth in a 60 consecutive month period
Crown repair	Once per tooth in any 24 consecutive months
Overcrown	Once per tooth in any 60 consecutive months
Repairs to complete or partial dentures	Once per appliance in any calendar year
Recement fixed or partial dentures	Once per appliance in any calendar year
Additions to partial dentures	As needed
Orthodontics Patients under 19 years of age	One course of treatment in a lifetime, up to $2,500
Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association. A "course of treatment" includes braces, monthly visits and retainers.	
Miscellaneous	
Occlusal guard	One appliance in any 60 consecutive month period

Alternate Benefit for Dental Coverage

There is often more than one way to treat a given dental problem. For example, a tooth could be repaired with an amalgam filling, a resin composite or a crown. If this is the case, the Plan will generally limit benefits to the least expensive method of treatment that is appropriate and that meets acceptable dental standards. For example, if your tooth can be filled with amalgam and you, or your dentist, decide to use a crown instead, the Plan pays benefits based on the amalgam. You will have to pay the difference.

What Is Not Covered

The Plan's dental coverage will not reimburse or make payments for the following:

- any services performed before a patient becomes eligible for benefits or after a patient's eligibility terminates, even if a treatment plan has been approved
- reimbursement for any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services
- orthodontia services for individuals age 19 or older
- charges in excess of the **allowed amounts**
- treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accident
- services or supplies that the Plan determines are experimental or investigative in

nature, except to the extent provided by law

- services or treatments that the Plan determines do not have a reasonably favorable prognosis
- any treatment performed principally for cosmetic reasons including, but not limited to, laminate, veneers and tooth bleaching
- special techniques, including precision dentures, overdenture, characterization or personalization of crowns, dentures, fillings or any other service. This includes, but is not limited to, precision attachments and stress-breakers. Full or partial dentures that require special techniques and time due to special problems, such as loss of supporting bone structure, are also excluded
- any procedures, appliances or restorations that alter the "bite", or the way the teeth meet (also referred to as occlusion and vertical dimension), and/or restore or maintain the bite, except as provided under orthodontic benefits. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for misalignment of teeth
- any procedures involving full-mouth reconstruction, or any services related to dental implants, including any surgical implant with a prosthetic device attached to it
- diagnosis and/or treatment of jaw joint problems, including temporomandibular joint disorder ("TMJ") syndrome, craniomandibular disorders or other conditions of the joint linking the jaw bone and skull or the complex of muscles, nerves and other tissue related to that joint
- double or multiple abutments
- treatment to correct harmful habits including, but not limited to, smoking and myofunctional therapy
- habit-breaking appliances, except under the orthodontics benefit
- services for plaque-control programs, oral hygiene instruction and dietary counseling
- services related to the replacement or repair of appliances or devices, including:
  - duplicate dentures, appliances or devices
  - the replacement of lost, missing or stolen dentures and appliances less than five years from the date of insertion or the payment date
  - replacement of existing dentures, bridges or appliances that can be made useable according to dental standards
  - adjustments to a prosthetic device within the first six months of its placement that were not included in the device's original price
  - replacement or repair of orthodontic appliances
- drugs or medications used or dispensed in the dentist's office (any prescriptions that are required may be covered by the Plan's prescription drug benefits. (See pages 58-59.)
- charges for novocaine, xylocaine, or any similar local anesthetic when the charge is made separately from a covered dental expense
- additional fees charged by a dentist for hospital treatment
- services for which a participant recovers costs from a third party, whether a claim is asserted or not, under Workers' Compensation, or automobile, medical, personal injury protection, homeowners or other no-fault insurance
- treatment of conditions caused by war or any act of war, whether declared or undeclared, or a condition contracted or an accident occurring while on full-time

active duty in the armed forces of any country or combination of countries

- any portion of the charges for which benefits are payable under any other part of the Plan
- if a participant transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for the same procedure, the Plan will not pay benefits greater than what it would have paid if the service had been rendered by one dentist
- transportation to or from treatment
- expenses incurred for broken appointments
- fees for completing reports or for providing records
- any procedures not listed under the Schedule of Covered Dental Services

Coordination of Dental Benefits

• When Delta Dental coverage is primary, Delta pays benefits under this Plan as if there is no other coverage.

• When Delta Dental is secondary, and there are remaining expenses of the type allowable under this Plan, Delta Dental will pay only the amount by which the benefits under this Plan exceed the amount of benefits payable under the other program.

The following rules will be followed to establish the order of determining the liability of this Plan or any other programs:
1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent child.

2. The program covering the enrollee as a dependent child of an employee whose birthday falls earlier in the calendar year will determine its benefits before the program covering the enrollee as a dependent child of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period. If the other program does not have the rule described in this paragraph, but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.

3. The program covering the enrollee having custody of the dependent child will determine its benefits first; then the program of the spouse, if any, of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent child, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.

4. The program covering the enrollee as an employee or as a dependent of an employee will determine its benefits before one that covers the enrollee as a laid off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.

5. If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary", Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not

have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.

6. In situations not described in items 1 through 5, the program under which the enrollee has been enrolled for the longest period of time will determine its benefits first. When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program.

7. When a dental procedure is eligible for coverage under both your hospital/medical plan and your dental plan, your hospital/medical plan will always be the primary payor.

Page 79: Filing Dental Claims, wherever ASO appears in this section it is deleted and replaced with Delta Dental. In addition, the ASO website address, www.asonet.com, is deleted and replaced with www.deltadentalins.com/32BJ.

Page 81: In the section *Where to Send Claim Forms*, the filing address for dental claims is deleted in its entirety and replaced with:

Delta Dental of New York
PO Box 2105
Mechanicsburg, PA 17055-2105

Page 86: In the section *Appealing Denied Claims*, in the chart, under the column *Level-One Appeal for Dental*, ASO, Inc. is deleted and replaced with Delta Dental.

Page 88: In the section *Where to File a Level-One Appeal*, under the column *Write to* ASO, Inc. and its corresponding address is deleted and replaced with:

Delta Dental of New York
Attn: Professional Services
One Delta Dental Drive
Mechanicsburg, PA 17055

In addition, under the chart, the phone number in the double asterisk for an urgent care dental claim, 1-800-294-5979, is deleted and replaced with 1-800-589-4627.

Back Cover: In the *Contact Information* chart, the contact information is deleted and replaced with:

Delta Dental Customer Service
Call 1-800-589-4627 or
Visit www.deltadentalins.com/32BJ

If you have any questions about this notice or want further information about the changes please contact Member Services at **1-800-551-3225** between the hours of 8:30AM and 5:00PM Monday through Friday or visit us on-line at www.32bjfunds.org.

The SPD is the official Plan document and controls the actual payment of benefits and the administration of this Plan. This SMM highlights the changes adopted by the Board of Trustees and does not replace the SPD.

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