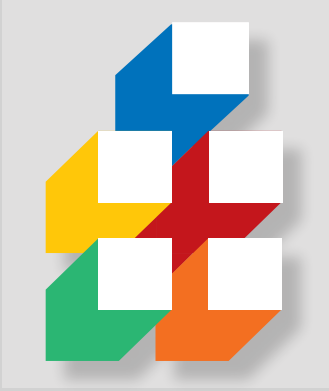
Building Service 32BJ Health Fund

Suburban Plan for the School District of Philadelphia



Summary Plan Description

April 1, 2015

Translation Notice

This booklet contains a summary in English of your Plan rights and benefits under the Building Service 32BJ 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 Building Service 32BJ 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 Building Service 32BJ 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 Building Service 32BJ 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.

Building Service 32BJ

Health Fund

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

The Building Service 32BJ 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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Contents

Important Notice

This booklet is both the Plan document and the Summary Plan Description ("SPD") of the plan of benefits ("the Plan") of the Building Service 32BJ Health Fund's ("the Fund") Suburban Plan for the School District of Philadelphia for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The terms 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, the insurance contracts, or 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 or union representative, 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. 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.

[1] This SPD is the Plan document for the Suburban Plan for the School District of Philadelphia which includes the hospital, medical, mental health and substance abuse, life insurance, and accidental death and dismemberment benefits. Insurance contracts from MetLife are the plan documents for the Life and Accidental Death & Dismemberment Insurance 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.

- This booklet describes the provisions of the Plan in effect as of April 1, 2015 unless specified otherwise.
- The level of contributions provided for in your collective bargaining agreement or participation agreement determines the Plan for which you are eligible. In general, the Suburban Plan for the School District of Philadelphia covers participants who work for the School District of Philadelphia.

While the Fund provides other plans, they are not described in this booklet. If you are unsure about which plan applies to you, contact Member Services for information.

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,
- life insurance, and
- accidental death and dismemberment.

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

2. Are my dependent(s) eligible?

Yes, if your collective bargaining or participation agreement provides for family coverage. In general, your covered dependent(s) include your spouse and your children until they reach 26 years of age. (See the table on pages 17–18 for a fuller description of dependent(s)).

3. 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, or
- Member Services by calling 1-800-551-3225.

4. 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, or 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.

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

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

- Visit the website https://provdir.ibx.com/, or
- Call 1-800-ASK-BLUE (1-800-275-2583).

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

$15.00.

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

You are covered for urgent or **emergency** care. Make sure you use a **participating provider** in a local BlueCross BlueShield **network**.

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

You will pay more. You will have to pay:

- $250 (the annual **deductible**),
- 30% of the **allowed amount**, and
- All charges above the **allowed amount**.

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. 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 Independence BlueCross' payment rate of allowed charges to a **network** provider.

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, two of which can be testing visits. (See pages 31–44 for all services with visit limits.)

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

$100. This is waived if you are admitted.

[(2)] Participants living outside certain counties in Pennsylvania, Maryland, Delaware and New Jersey have the Independence BlueCross Personal Choice Preferred Provider Organization ("PPO") **network**. (See page 22.)

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, Echocardiography and Nuclear Medicine tests),
- Other Imaging Services (echo stress tests),
- Hospital and inpatient surgery,
- Inpatient Hospice Care,
- 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, Prosthetics and Orthotics,
- Home care services, including infusion therapy,
- Air ambulance (non-emergency),
- Ambulatory surgery (reconstructive, cosmetic and optical procedures), and
- Outpatient Services, including hyperbaric oxygen therapy, proton beam therapy and sleep studies.

When you use **participating providers**, the provider will get the prior authorization for you.

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

There is no out-of pocket cost if you use an **in-network** hospital. 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 an **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 prescription drugs, dental or vision benefits covered?

No. These benefits are not provided under this Plan.

16. What is my life insurance coverage?

$25,000.

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

17. 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 67–70 for more information.)

18. If I change 32BJ covered employers, what happens to my health coverage?

If you change covered **employers** and you have a break of 91 days or less in employment, your coverage will begin on your first day back at work. If there is more than a 91 day break in employment, your coverage will not begin until you complete 90 consecutive days of employment with your new covered **employer**.

19. If I leave the industry, 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 coverage for up to 17 more months.

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

You may be eligible, for up to 30 months[3] of continued health coverage at no cost to you. To be eligible, you must:

- Have become disabled while working in **covered employment,**
- Be unable to work, and
- Be receiving (or be approved to receive) one of the following benefits:
  - Short-term Disability ("STD"), or
  - Workers' Compensation.

[3] Up to 12 months of coverage is provided by the School District of Philadelphia and up to 18 months is provided by the Fund under the Health Extension. All coverage counts toward the period in which you are entitled to continuing coverage under COBRA.

21. 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.

22. 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.

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 more than two days a week, 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. 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.**

When You Are No Longer Eligible

Your eligibility for the Plan ends:

- at the end of the 30th day after you no longer regularly work in **covered employment**, subject to COBRA rights. (See pages 14–16 and pages 76–81.),
- on the date when your **employer** terminates its participation in the Plan, or
- on the date the Plan is terminated.

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** or a different **contributing employer**):

- within 91 days, your Plan participation starts again on your first day back at work, or
- more than 91 days later, you would have to complete 90 consecutive days of **covered employment** with the same **employer** before participation resumes.

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 17–19) and you have properly enrolled them.

Extension of Health Benefits

Health coverage may be continued while you are not working in the following circumstances:

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 Plan's hospital, medical, and behavioral health and substance abuse coverage. It does not include life insurance or accidental death & dismemberment ("AD&D"). (See pages 76–81 for more information about COBRA.)

Health Extension

If all eligibility requirements are met, either the School District of Philadelphia or the Fund will pay for health coverage in the following situations: disability, which must have occurred while you were in **covered employment**, and arbitration. All periods of the Health Extension will count toward the period in which you are entitled to continuing coverage under COBRA. The Health Extension includes the Plan's hospital, medical, and behavioral health and substance abuse benefits. Life insurance and AD&D are continued only for the first six months. (See pages 51–52 for the Life Insurance Disability Extension.)

To receive this extended coverage, return the documentation from the list in the Health Extension section of the COBRA election notice. If you fail to timely return the required documentation, you may lose eligibility for continuation of coverage under the Health Extension. The required documents (e.g., proof of disability), must be returned to:

COBRA Department
Building Service 32BJ Benefit Funds
25 West 18th Street
New York, NY 10011-4676

Disability

You may continue to be eligible for up to 30 months of health coverage [4] (see Health Extension above) provided you return the required documentation set forth in the Health Extension section of the COBRA election notice, are unable to work and are receiving (or are approved to receive) one of the following disability benefits:

- Short-Term Disability, or
- Workers' Compensation.

When any of the following events occur, your extended coverage will end:

- you elect to discontinue coverage,
- you work at any job,
- 30 months have passed after you stopped working due to disability,

[4] Up to 12 months of coverage is provided by the School District of Philadelphia and up to 18 months is provided by the Fund under the Health Extension.

- your Workers' Compensation or Short-Term Disability ends,
- you receive the maximum benefits under Short-Term Disability or Workers' Compensation, or
- you become eligible for Medicare as your primary insurer.

If you die while receiving extended coverage, your dependent(s)' eligibility will end 30 days after the date of your death.

To receive this extended coverage (Health Extension), you must submit proof of disability as described in the Health Extension section of the COBRA election notice no later than 60 days after the date coverage would have been lost (90 days after you stopped working due to a disability). The Plan reserves the right to require proof of your continued disability from time to time. This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA. (See pages 14–16 and pages 76–81 for COBRA information.)

Arbitration

If you are discharged* and the Union takes your grievance to arbitration seeking reinstatement to your job, your coverage will be extended for up to six months or until your arbitration is decided, whichever occurs first. (See Health Extension on pages 15–16.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

FMLA

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 coverage during an FMLA leave. (See pages 74–75 for more information.)

Military Leave

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 coverage. (See pages 75–76 for more information.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

* Indefinite suspensions or suspensions pending discharge are treated the same as discharges.

Dependent Eligibility

If your collective bargaining agreement or participation agreement provides for dependent coverage, 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).
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:

- 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 20–21). 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[(5)] or divorce.

[(5)] 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.

- Your child's eligibility ends on the date your child no longer satisfies the requirements for a dependent child as described on pages 17–19, 30 days after the child's 26th birthday, or the end of the calendar year in which the child turns 26, whichever is earlier.
- 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 17–19 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 20–21 for further details.)

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 pages 17–19.

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, life insurance, and accidental death and dismemberment benefits. Each of these benefits is described in the sections that follow.

Annual Out-Of-Pocket Maximum on In-Network Hospital, Medical, Mental Health and Substance Abuse 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 benefits. Your annual out-of-pocket maximum is $5,000 and your family's annual out-of-pocket maximum is $10,000.*

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.

* 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 1st in proportion to HHS' limits.

Hospital, Medical, Mental Health and Substance Abuse Benefits

The Plan provides hospital, medical, mental health and substance abuse benefits through Independence BlueCross ("IBC"). The Plan offers the Independence BlueCross Keystone Direct Point-of-Service ("POS") **network**.[6] This **network** includes thousands of **doctors** and other providers, and over one hundred hospitals in the Philadelphia metropolitan area which includes the following counties in the following four states:

- *Pennsylvania: Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northhampton and Philadelphia counties.*
- *New Jersey: Burlington, Camden, Gloucester, Hunterdon, Mercer, Salem and Warren counties.*
- *Delaware: New Castle county.*
- *Maryland: Cecil county.*

Participants who reside outside of these counties in Pennsylvania, New Jersey, Delaware, or Maryland identified above will receive their hospital, medical, mental health and substance abuse benefits through the Independence BlueCross Personal Choice 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.

IBC ID Card. This card gives you access to thousands of **doctors**, surgeons, hospitals and other health care facilities in the **network**. You must present this ID card whenever you receive services.

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.

All IBC Keystone Direct POS members must choose a primary care **physician** ("PCP") from the **network** of participating POS providers. This PCP selected will be printed on each member's ID card. Each member of your family can select their own PCP. You can all have the same PCP or you can each have your own individual PCP. Call IBC Customer Service at 1-800-275-2583 for assistance in selecting your PCP. You can also find a listing of participating POS PCPs at https://provdir.ibx.com/.

Your PCP will be responsible for making a referral for four specific services – x-rays, physical therapy, occupational therapy and lab services. You must get a referral from your PCP for these services. You do not need a referral to see any other **participating providers** in the POS **network**. You can go directly to all other **participating providers** without a PCP referral.

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 **participating provider**, your **co-payment** for participating **physicians** and specialists is $15 per office visit.

The **co-payment** for all participating mental health or substance abuse professionals is $15 per office visit.

[6] 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.

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 IBC Member Services at 1-800-275-2583) 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 70% 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 31-44 for additional information.)**

If you use an **out-of-network provider**, ask your provider if he or she will accept IBC's payment as payment in full (excluding your **deductible** or **co-insurance** requirements). While many providers will tell you that they take "IBC " 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 IBC's payment as payment in full, it is best to get their agreement in writing.

If your provider does not accept IBC's payment as payment in full, in addition to the 30% of the **allowed amount** you pay, you will then be responsible for the excess charges.

*Annual **deductible***. Your individual annual **deductible** is $250 and your family annual **deductible** is $500.

*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 45–50.)

Co-insurance. Once the annual **deductible** is met, the Plan pays 70% of the **allowed amount** for eligible **out-of-network** expenses. You pay the remaining 30%, 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 $750 and your family **co-insurance** maximum is $1,500. 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 45–50.)

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 70% of the **allowed amount**.

Your Explanation of Benefits will show the maximum amount the provider can charge you. This will be reflected in the column labeled "Amount You Owe Provider".

In addition to the 30% 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	$250	$0
Co-insurance	$318	$742
Amount above the **allowed amount**	$3,690	$0
Total	**$4,258**	**$742**

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 98), you are covered for all urgent and **emergency** 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 31–44.)

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.

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 IBC, 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 1-800-275-2583 24 hours a day, seven days a week**.**

For inpatient mental health/substance abuse that require prior authorization, providers and members call 1-800-688-1911 24 hours a day, seven days a week**.**

Type of Care	When You Must Call
Outpatient: • Air ambulance[9] (non-emergency) • Outpatient services for hyperbaric oxygen therapy, proton beam therapy and sleep studies • MRI or MRA scans • PET, CAT, echocardiography and nuclear imaging studies • Echo sress tests • Prosthetics/orthotics or durable medical equipment (rental or purchase) • Intensive outpatient services for behavioral or substance abuse • Home care services, including infusion therapy • 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.

See footnote 9 on page 98.

How pre-certification works. IBC'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 two business days after they have received all necessary information. In urgent care situations, IBC's Medical Management Program will make its decision *within 72 hours* after they have received all necessary information. (For more information, see pages 56–66.)

If you do not pre-certify the care (except for pre-natal care) listed above and on the previous pages 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.*

* Prior to July 1, 2016, the penalty was a 20% reduction in benefit payments for each admission.

Overview of Out-of-Pocket Expenses

There are no lifetime or annual dollar maximums for benefits. Some benefits have annual visit maximums. (See Schedule of Covered Services on pages 31–44 in this booklet.)

Type of Care	**Out-of-Pocket Expense by Place of Service**	
Doctor Visits	**In-Network Co-Payment**	**Out-of-Network Expense**
	Participating Doctor/Provider	**Non-Participating Providers**
Doctor's office	$15	You pay the **deductible**, 30% of the **allowed amount** and any balance billing.
Urgent care center	$15	
Mental health or substance abuse visit	$15	
Preventive care services	$0	

Hospital & Facility Visits	**Participating Hospital or Facility Co-Payment**	**Non-Participating Hospital or Facility Expense**
Hospital emergency room	$100 per visit. Waived if admitted.	
Hi- tech radiology (CAT, MRI, MRA,PET, and nuclear studies)	No charge	You pay the **deductible**, 30% of the **allowed amount** and any balance billing.
Hospital inpatient	No charge	
Hospital outpatient department	No charge	

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%	Plan pays 70% 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 footnote 1 on pages 95–96 and footnote 3 on page 96.

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

Benefit	In-Network	Out-of-Network	Limitations
Bariatric surgery*	Plan pays 100%	Not Covered	Only covered at Blue Distinction Hospitals in the IBC **network.**
Transplant surgery* Lifetime travel maximum for a transplant	Plan pays 100% $10,000 per transplant		Transplants are covered only at Blue Distinction Centers of Medical Excellence.[1] Call IBC 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 definitions of various facilities and further details, see footnote 1 on pages 95–96, footnote 4 on page 96 and footnote 5 on page 97.

Emergency Care

Benefit	In-Network	Out-of-Network	Limitations
Emergency room[8] ("ER") in a hospital	Plan pays 100% after $100 **co-payment**		Waived if admitted
Urgent care center	Plan pays 100% after $15 **co-payment**	Plan pays 70% of the **allowed amount** after the **deductible**	
Ambulance service[9]	Plan pays 100%		

See footnotes 8 and 9 on page 98.

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%	Plan pays 70% of the **allowed amount** after the **deductible**	
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, and nuclear imaging)*	Plan pays 100%	Plan pays 70% of the **allowed amount** after the **deductible**	

* Pre-certification required.

See footnotes 2 and 3 on page 96.

Care in the **Doctor's** Office

Benefit	In-Network	Out-of-Network	Limitations
Office visits (including surgery[2] in the office)	Plan pays 100% after **co-payment** for office visits with **in-network providers**. (See Overview of Out-of-Pocket Expenses on page 30.)	Plan pays 70% 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 Independence participating lab, such as LabCorp.
Hi-tech imaging (CAT, MRI, MRA, PET, and nuclear imaging)*	Plan pays 100%		
Chiropractic visits	Plan pays 100% after **co-payment.** (See Overview of Out-of-Pocket Expenses on page 30.)		Limited to ten visits per calendar year.
Podiatric care, including routine foot care	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on page 30.)		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 page 30.)	Not Covered	**In-network** only. Limited to 20 visits per calendar year.

* Pre-certification required.

See footnote 2 on page 96 and footnote 10 on page 99.

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 page 96, footnotes 5 and 6 on page 97 and footnote 7 on page 98.

Mental Health and Substance Abuse

Benefit	In-Network	Out-of-Network	Limitations
Mental health care:			
Inpatient mental health*	Plan pays 100%	Plan pays 70% of the **allowed amount** after the **deductible**	
Physician office visits	Plan pays100% after $15 **co-payment**		
Outpatient hospital facility*	Plan pays 100%		
Substance abuse care:			
Inpatient substance abuse*	Plan pays 100%		
Physician office visits	Plan pays 100% after $15 **co-payment**		
Outpatient hospital facility*	Plan pays 100%		

* Pre-certification required.

Preventive Medical Care*

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 70% 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 page 99			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
1 month old	1 exam
2 months old	1 exam
3 months–18 months old	an exam every 2–3 months
19 months–3 years of age	once every 6 months
3–19 years of age	once every year

* See page 39.

See footnotes 11 and 12 on page 99.

Preventive Medical Care* (continued)

Benefit	In-Network	Out-of Network	Limitations
Routine immunizations –all ages (includes travel immunizations)	Plan pays 100% $0 **co-payment**	Plan pays 70% 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			

* The Plan covers certain preventive care services without imposing any **co-payments** when using an **in-network provider**. The four areas of preventive care services are:

- 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 table above and on the preceding page. The list of preventive care services may change. You may find a list of preventive care services at www.hhs.gov or by contacting Member Services at 1-800-551-3225.

** 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**.

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 70% of the **allowed amount** after the **deductible**	
Vasectomy (excludes reversals)	Plan pays 100% after **co-payment**. (See Overview of Out-of-Pocket Expenses on page 30.)		The type of facility where service is provided will determine **co-payment**.
Abortion, includes elective and non-elective procedures			
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 page 30.) No **co-payment** for first postnatal visit.	Plan pays 70% 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%	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 70% 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			

* Pre-certification required.

See footnotes 13 and 14 on page 99.

Physical, Occupational, Speech or Vision Therapy (Including Rehabilitation)[15]

Benefit	In-Network	Out-of Network	Limitations
Inpatient services*	Plan pays 100%	Plan pays 70% 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 page 30.)	Not Covered	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 99.

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 70% 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 70% 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 page 100.

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 page 30.)	Plan pays 70% of the **allowed amount** after the **deductible**	
Repair to natural teeth only within 12 months of injury to sound natural teeth			

*Dental benefits are not provided under this Plan.

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:

- 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 Independence'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 (This bullet is eliminated on January 1, 2016.)
- 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 except as provided for eligible reimbursements under IBC's Healthy Lifestyles Solutions Programs
- 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 100–101.

- 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 Social Workers, 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 97
- 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 93.)
  - 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 Independence's definition of a hospital or other covered facility
  - bariatric surgery at a facility that is not a Blue Distinction Hospital within the IBC **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 100.

- 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, lung and pancreas performed at a hospital that is not a Blue Distinction Center of Medical Excellence facility
  – transplant surgery for a kidney performed at a non-participating Independence 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
- 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
  – routine vision care
- the following services:
  – 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
  – all prescription drugs and over-the-counter drugs, self-administered injectibles, vitamins, vitamin therapy, appetite suppressants, or any other type of medication, unless specifically indicated
  – false teeth (not covered under hospital/medical, but may be covered under your dental plan with Local 1201. See Local 1201 Summary Plan Description).
- 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 71–73)
  – 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 71–73)
– 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
– 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

Life Insurance Benefits

Benefit Amount

Your life insurance coverage is administered by MetLife. Your life insurance coverage is $25,000. 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. 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.

The Fund reserves the right to re-certify disability as described on pages 15–16. 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 pages 60–66 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 and on the preceding page, or if you have Health Extension due to disability or arbitration. (See page 15.) See page 83 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 $25,000. 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 $12,500.

"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 infirmity, or the diagnosis or treatment of such illness or infirmity,
- infection other than occurring in an external accidental wound,
- suicide or attempted suicide,
- intentionally self-inflicted injury,
- service in the armed forces of any country or international authority, except the United States National Guard,
- any incident related to travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; parachuting or other descent from an aircraft, except for self-preservation; travel in an aircraft or device used: for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the Earth's atmosphere,
- committing or attempting to commit a felony,
- the voluntary intake or use by any means of any drug, medication or sedative, unless it is taken or used as prescribed by a **physician**, or an "over the counter" drug, medication or sedative taken as directed; alcohol in combination with any drug, medication, or sedative; or poison, gas, or fumes,

- war, whether declared or undeclared; or act of war, insurrection, rebellion or riot, or,
- the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Coverage Ends

AD&D insurance coverage ends 30 days after you terminate employment. Like your life insurance, your AD&D coverage may continue while you have Health Extension due to disability or arbitration. (See pages 15–16.)

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, and
- a request for prior approval of a benefit that does not require prior approval by the Plan.

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 or 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 below 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 IBC 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 67–70.)
- Keep a copy of your claim form and all attachments for your records.

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.

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)	Claims Servicing Center P.O. Box 69353 Harrisburg, PA 17106-9353
Life Insurance Accidental Death & Dismemberment	Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100

Approval and Denial of Claims

There are separate claims denial and approval processes for Health Services Claims (hospital, medical, mental health and substance abuse) and Life/AD&D 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)

The time frames for deciding whether Health Services Claims are approved or denied depend 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, certain outpatient hospital benefits and mental health and substance abuse benefits (see the table on pages 28–29). For properly filed pre-service claims, you and/or your **doctor** 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 *5 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.

* 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.

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:

  – 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 insurance 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.

Notice of Decision

You will be provided with written notice of a denial of a claim that sets forth the reason(s) for the 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 54–66.

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) and Life/AD&D 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)	IBC	IBC through an Independent Review Organization ("IRO")
Health Services Claims (Administrative)	IBC	Board of Trustees*
Life/AD&D	Metropolitan Life Insurance Company	Board of Trustees*

*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, 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	Independence BlueCross Attention: Member Appeals P.O. Box 41820 Philadelphia, PA 19101-1820 Fax: 1-888-671-5274	1-888-671-5276
Life Insurance Accidental Death & Dismemberment	Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 1-570-558-8645	Appeals are only accepted in writing

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) 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 Health Services (Hospital, Medical, Mental Health and Substance Abuse) Claim Appeal

If you file an appeal of a pre-service (service not yet received) or concurrent (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) 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 (2) your appeal involves non-authorization of an admission or a continuing inpatient hospital stay. IBC's **physician** reviewer, in consultation with the treating **physician**, will decide if an expedited appeal is necessary. When an appeal is expedited, IBC will respond orally with a decision *within 72 hours*, and IBC will also send a written notice of the decision.

Second Level of Appeal for Health Services Claims (Hospital, Medical, Mental Health and Substance Abuse) Involving Medical Judgment

If you are not fully satisfied with the decision of IBC's level-one appeal decision of a claim that involved Medical Judgment, 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 IBC, 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. 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 Medical Judgment or clinical appropriateness determination by IBC. 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 IBC *within 4 months* of the date of IBC's level-one appeal denial letter. IBC 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 IBC'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*.

Voluntary Level of Appeal

Administrative Health Services (Hospital, Medical, Mental Health and Substance Abuse) and Life/AD&D

Once you have received notice of the denial of your timely[6] level-one appeal of an administrative[7] Health Services Claim, or level-one appeal of 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 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 this 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. **In addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied**. Alternately, you may file a voluntary appeal with the Appeals Committee of 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 on page 60.

[6] The Appeals Committee 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' Appeals Committee.

[7] An administrative Health Services 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.

The voluntary level of appeal is available only after you, or your authorized 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 authorized 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 authorized 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 authorized 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 Appeals Committee at the following address:

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

If you, or your authorized representative, choose 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 Notice

You will be notified in writing in five days from the date your appeal is reviewed by the Appeals Committee of the decision of your appeal.

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.** If there is no decision on the appeal, no lawsuit may be started more than three years after the time when the Appeals Committee 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 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.
- If you are not in **covered employment** 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 71-73).

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(s), 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, institute a lawsuit, 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:

Trover Solutions, Inc
9390 Bunsen Parkway
Louisville, KY 40220
Phone: 1-866-352-8768

Overpayments

- If you (or your dependent(s) or beneficiary) are overpaid for a claim, you (or your dependent(s) 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(s) 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 14–16 and pages 76–81 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 pages 69–70.)

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 an 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 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.

If you are disabled and receiving (or are approved to receive) benefits under statutory short-term disability or Workers' Compensation, the Plan provides coverage for up to 30 months[8] as long as you remain disabled, are unable to work and you apply for coverage. If you are terminated by your **employer** and your termination is going to arbitration seeking reinstatement, the Plan provides coverage for up to six months. In these two cases of extended COBRA coverage, you do not have to pay the premium since it is paid by the Fund. Keep in mind that the maximum period that you have COBRA coverage is reduced by any period of time you received the Health Extension coverage.

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:

[8] Up to 12 months of coverage is provided by the School District of Philadelphia and up to 18 months is provided by the Fund under the Health Extension.

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 child(ren) 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 77.)

*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 are not available, except as provided under the Health Extension for up to six months. 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 77. 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.
- 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 91.

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 91.

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 91.

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 $25,000 you had under the group Plan.

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 or AD&D benefits to individual coverage.

General Information

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between the Philadelphia School District, or various independent **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 and the 32BJ Benefit Funds) 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 and, if so, to which Plan the employer is contributing.

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 eighteen (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 76–81).

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 71–73 and Overpayments on page 74.)

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 dependents 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 designee(s), including the Appeals Committee with regard to benefit claim appeals, 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 delegated certain administrative and operational functions to the Fund staff, other organizations and to the Appeals Committee. 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
Building Service 32BJ 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 Building Service 32BJ 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 14–16 and pages 76–81 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.

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.

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

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 56–66. 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 Suburban Plan for the School District of Philadelphia of the Health Fund.

Plan Name: Building Service 32BJ Health Fund
Employer Identification Number: 13-2928869
Plan Number: 501
Plan Year: July 1 – June 30
Type of Plan: Welfare Plan

Funding of Benefits and Type of Administration

Self funded, except MetLife insures the Life and AD&D insurance benefits. All contributions to the Trust Fund are made by **contributing employer**s under the Plan in accordance with their written agreements. Benefits are administered by the organizations listed in the table on page 60.

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
Building Service 32BJ 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
Building Service 32BJ Benefit Funds
25 West 18th Street
New York, NY 10011-4676

To contact the Health Fund, call:

1-800-551-3225

or write to:

Building Service 32BJ 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.

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 30% 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, emergency room visits and certain **covered services** 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 or IBC 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 Independence BlueCross' 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 benefits are benefits for **covered services** provided by **out-of-network providers** and **suppliers**.

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 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 medical plan.

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 Independence BlueCross 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 Independence BlueCross or participating with Independence BlueCross or, for PPO participants, another BlueCross and/or BlueShield plan other than specified above.

For kidney dialysis treatment, covered **in-network** only at hospitals within the Independence BlueCross **network**, a facility in Pennsylvania qualifies for **in-network benefits** if the facility has an operating certificate issued by the Pennsylvania State Department of Health, and participates with Independence BlueCross 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 Pennsylvania'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 facility's 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 IBC.

IBC 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 free-standing 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, are approved for use by the most recent "Physician's Desk Reference" and are related to the patient's condition for hospice services,
- 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 administered by a clinician, 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 Independence BlueCross 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 Independence BlueCross ID card within 48 hours after an **emergency** hospital admission, as described on pages 28–29, to pre-certify any continued stay in the hospital. If you have an **emergency** outside the Independence BlueCross POS Operating Area (see pages 24–29 and page 33), show your Independence BlueCross 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 Hyperbaric 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*** under the Plan includes routine physicals, subject to limits shown on pages 38–39. Eligible expenses include x-rays, laboratory or other tests given in connection with the exam and materials for immunizations for infectious diseases. *Adults are covered for immunizations* if **medically necessary**.

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 38–39. 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 and influenza, HPV, Rotavirus, Meningococcal – polysaccharide and conjugate, and other immunizations as determined by the American Academy of Pediatrics.

13 ***Services of a certified nurse-midwife*** are covered if he or she 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 Independence BlueCross POS Obstetrician/Gynecologist global rate.

15 ***Physical therapy*** is covered for up to 30 days of covered inpatient physical therapy per person per year. 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 Independence BlueCross 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, mental health and substance abuse benefits	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday
• To find a primary care **physician** • To find participating IBC providers	IBC	Call 1-800-ASK-BLUE (275-2583) or Visit https://provdir.ibx.com/
• Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit https://mybenefits.metlife.com
• To pre-certify a hospital or medical service	IBC	Call 1-800-ASK-BLUE (275-2583)
• To help prevent or report health insurance fraud (medical or hospital)	IBC	Call 1-800-ASK-BLUE (275-2583)
• Help with family and personal problems like depression, alcohol and substance abuse, divorce, etc.	IBC	Call 1-800-ASK-BLUE (275-2583)

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

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

Summary of Material Modifications
Building Service 32BJ Health Fund
Suburban Plan for the School District of Philadelphia

The following is a list of changes and clarifications which have occurred since the printing of the Building Service 32BJ Health Fund Summary Plan Description (SPD) for the Suburban Plan for the School District of Philadelphia dated April 1, 2015. This Summary of Material Modifications (SMM) supplements or modifies the information presented in your SPD with respect to the Plan. **Please keep this document with your copy of the SPD for future reference.**

Change in Executive Director, Building Service 32BJ Benefit Funds Page 1: Effective January 1, 2018, Peter Goldberger has replaced Susan Cowell as Executive Director of the Building Service 32BJ Benefit Funds.

Change in Director, Building Service 32BJ Health Fund Page 1: Effective May 19, 2018, Sara Rothstein has replaced Angelo V. Dascoli as Director of the Building Service 32BJ Health Fund.

Change in Fund Auditor 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 10: 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 31–44 for all services with visit limits.)

Change in Emergency Room Co-payment Pages 10 (FAQ 11), 30 and 33: Effective January 1, 2017, the co-payment for emergency room visits is $100 each visit for the first 2 emergency room visits per calendar year and $200 for each visit thereafter.

Addition of Hospital Admission Co-payment Pages 11 (FAQ 13), 30 and 31: Effective January 1, 2017, the co-payment for an in-network hospital admission is $100.

Clarification on Cancelation of Coverage When Eligible for Medicare Page 13: the following new bullet is added after the first bullet in the list under the section *When You Are No Longer Eligible*:

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

Addition of Explanation of Annual Out-of-Pocket Maximum on In-network Benefits Page 21: 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

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 benefits. Your annual out-of-pocket maximum is $5,550 and your family's annual out-of-pocket maximum is $11,100.* 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.

Your annual out-of-pocket maximum for **in-network** medical benefits is $5,550 and your family's annual out-of-pocket maximum for **in-network** medical benefits is $11,100. After a family has spent $11,100 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.

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.

*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.

Effective January 1, 2019, the medical portion of the MOOP is increased to $6,100/individual and $12,200/family.

Change in Specialist Co-payment Pages 23 and 30: Effective January 1, 2017, the co-payment to see a participating specialist is increased from $15 to $40.

Addition of Telephone Number for Member to Call to Get An Estimate of What it Would Cost to Use a Non-Participating Provider Page 26: The following paragraph is added after the last paragraph on page 26:

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 IBC at 1-800-275-2583. In order to assist you, IBC 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 28: The following services are added to the chart on page 28 in the column *Type of Care* under Outpatient:

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

Addition of Hi-tech Radiology (CAT, MRI, MRA, PET and nuclear studies) Co-payment Pages 30, 34 and 35: Effective January 1, 2017, there is a $75 co-payment on Hi-tech Radiology (CAT, MRI, MRA, PET and nuclear studies).

Addition of Hospital Outpatient Co-payment Pages 30, 34 and 37: Effective January 1, 2017, there is a $75 co-payment on all services received in a Hospital Outpatient setting, with the following exceptions:

- there is no Hospital Outpatient co-payment for out-patient maternity,
- there is no Hospital Outpatient co-payment for blood work,
- there is only one Hospital Outpatient co-payment per calendar year on chemotherapy and radiation therapy,
- there is only one Hospital Outpatient co-payment per episode of treatment for intensive outpatient mental health or substance abuse services, and
- there is a $40 per visit co-payment for services received at a hospital clinic.

Addition of Exclusion on Non-participating Substance Abuse Providers Pages 30 and 37: 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 30 and to the Limitations column for all Substance Abuse care (inpatient substance abuse, physician office visits and outpatient hospital facility) on page 37:

> Non-participating New York inpatient and outpatient substance abuse providers that are not certified and/or licensed by the Office of Alcoholism and Substance Abuse Services and non-participating providers in all other states that are not certified by a similar state agency and which are not accredited by The Joint Commission are not covered.

Addition of Gender Reassignment Surgery Page 32: 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
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 33: The chart on page 33, 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 $15 **co-payment**	Plan pays 70% 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 98.

* 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**.

Addition of Hyperbaric Oxygen Treatment Page 34: 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 where service is provided: If in outpatient hospital setting – $75 **co-payment** If in freestanding surgical facility – $0	Plan pays 70% 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.

	co-payment		Note: There is no **co-payment** for blood tests done in an **in-network** hospital outpatient setting.

Clarification in Coverage of Allergy Visits Page 35: 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 40: 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 70% 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 page 30.)</td><td></td></tr>
<tr><td>Abortion includes elective and non-elective procedures</td><td>The type of facility where service is provided will determine co-payment.</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>

Clarification on Cancelation of Coverage When Eligible for Medicare Page 52: 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 68.)

Clarification on Cancelation of Coverage When Eligible for Medicare Page 54: 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 68.)

Addition of Section "No Duplication of Health Coverage": Page 66: The following section is inserted after the section titled *Incompetence:*

No Duplication of Health Coverage

Even if more than one employer makes contributions on your behalf at the same time to this **Fund**, you will receive only one Plan of benefits. The Plan of benefits that you will receive is the Plan that is determined by the **Fund** to be the Plan that, in totality, offers you the greatest benefits.

Clarification on Cancelation of Coverage When Eligible for Medicare Page 68: Under the first bullet in the section *Medicare*, the following sentence is added at the end of the bullet:

> When you cancel coverage under this Plan all benefit coverage is cancelled including medical, hospital, mental health and substance abuse and Life Insurance & Accidental Death and Dismemberment.

Change in Fund Subrogation Administrator Name Page 73: Trover Solutions, Inc. has merged with Equian, LLC and changed its name to Equian, LLC.

Change in Fund Auditor 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 of Payment Responsibility when Medicare is Primary and Health Fund is Secondary Page 79: The following paragraph is added immediately preceding the start of the last paragraph:

> 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 81: The following is added to the end of the third 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 IBC identification 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 92 is deleted in its entirety and replaced with the following:

The **allowed amount** is not what the **doctor** charges you for a covered service. It is the amount that the Plan will pay for a **covered servic**e, and it is generally a lower amount than what the **doctor** charges for the covered service. When you go **in-network**, the **allowed amount** is the amount Independence Blue Cross (the amount may also be an amount that another Blue Plan and the provider have agreed to) 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 for a covered service. The Medicare reimbursement rate varies based on the covered service. The allowed amount for an out-of-network covered services will not be based on what providers in the geographic area usually charge for the same or similar medical service, which is commonly referred to as the usual, customary and reasonable ("UCR") rate.

> **Page 10**: The above paragraph is also added after the last sentence in the answer to FAQ 9.

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 8:30 AM and 5:00 PM Monday through Friday or visit us on-line at www.32bjfunds.org.