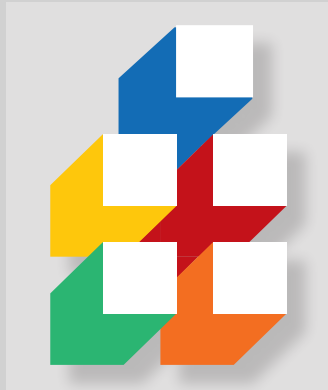




Building Service 32BJ Health Fund
Metropolitan and
Suburban Plans



Summary Plan Description

April 1, 2020



Translation Notice

This booklet contains a summary in English of your rights and benefits under the 32BJ Health Fund Metropolitan and Suburban Plans. 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
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 32BJ Health Fund Metropolitan and Suburban Plans. Si tiene alguna dificultad para entender cualquier parte de este folleto, llame al Centro de servicios para afiliados al 1-800-551-3225, o escriba a la dirección siguiente:

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

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

Niniejsza broszura zawiera opis, w języku angielskim, Twoich praw i świadczeń w ramach Planu 32BJ Health Fund Metropolitan and Suburban Plans. 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
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.

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Member Services
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.

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

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Important Notice

This booklet is both the Plan document and the Summary Plan Description (“SPD”) of the plan of benefits (the “Plan”) of the Building Service 32BJ Health Fund’s (the “Fund”) Metropolitan and Suburban Plans of benefits for purposes of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The terms contained herein constitute the terms of the Plan.* Your rights to benefits can only be determined by this SPD, as interpreted by official action of the Board of Trustees (the “Board”). You should refer to this booklet when you need information about your Plan benefits. In addition, the Board reserves the right, in its sole and absolute discretion, to amend the Plan at any time.

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

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

* This SPD is the Plan document for the Metropolitan and Suburban Plans. These Plans include hospital, medical, behavioral health and substance abuse, prescription drug, dental, vision, life insurance and accidental death and dismemberment benefits and a pensioner death benefit. The Metropolitan Plan also provides long-term disability benefits. The Suburban Plan includes insured short-term and long-term disability benefits through Guardian Life Insurance of America. Insurance contracts from MetLife are the plan documents for the Life and Accidental Death & Dismemberment Insurance Plans, and those contracts as amended or issued from time to time, are incorporated herein by reference. Insurance contracts from Guardian Life Insurance of America are the plan documents for the short and long-term disability benefits offered under the Suburban Plan, and those contracts as amended or issued from time to time, are incorporated herein by reference. 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 Plan pays the premiums required to keep the insurance policies in force, but the Plan does not directly pay any insured benefits. The Board reserves the right to change insurance carriers and contracts. If the Board makes any such changes, the benefits coverage described in this SPD may not be accurate. You may request copies of the insurance contracts from MetLife and Guardian.

- The word “dependent” refers to a family member of a participant who is eligible for Plan benefits. In the sections describing the benefits payable to participants and dependent(s), the words “you” and “your” may also refer to the patient.
- This booklet describes the provisions of the Plan in effect as of April 1, 2020, unless specified otherwise. If you are a retiree and are eligible for Plan benefits, you are eligible for the current Plan benefits, not the Plan benefits in effect at the time you stopped working.
- The level of contributions provided for in your collective bargaining agreement or participation agreement determines the Plan for which you are eligible unless otherwise determined by the Trustees. In general, the Metropolitan Plan covers participants who work in residential and commercial employment in Manhattan, Brooklyn, Queens and Staten Island. Note that most Security Officers are covered by the Basic Plan, which has a separate booklet. In general, the Suburban Plan covers participants who work in New York City public schools, in Westchester and Long Island residential employment, in Co-op City in the Bronx, and in other locations outside the New York metropolitan area, including New England.

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.

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:

Most collective bargaining agreements and participation agreements require your **employer** 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. If your collective bargaining agreement or participation agreement has an earlier start date for contributions, you will be eligible on the contribution start date. If your collective bargaining agreement or participation agreement is silent regarding the start date of contributions, contributions begin on your first day of **covered employment**. 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 the 91st day of **covered employment**.

Additional eligibility requirements apply to retirement between ages 62 and 65 (see pages 10–11), long-term disability benefits (see pages 70–73) and death benefit for pensioners (see page 75–76).

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 14–16) and you have properly enrolled them.

When You Are No Longer Eligible

Your eligibility for the Plan ends on the earliest of the following dates:

- at the end of the 30th day after you no longer regularly work in **covered employment** (this does not apply if you are eligible for Fund-paid Health Extension), subject to COBRA rights. (See pages 10–14 and pages 107–112.),
- at the end of the period of Fund-paid Health Extension, subject to COBRA rights. (See pages 10–14.),
- on the date when your **employer** terminates its participation in the Plan,

- on the date the Plan is terminated, or
- on the date you cancel your coverage because you are eligible for Medicare. (See pages 98–99.)

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 you became eligible to participate in the Plan 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 a new waiting period of 90* consecutive days of **covered employment** with the same **employer** before participation resumes.

Extension of Health Benefits

In certain circumstances, you may continue your health coverage even after you stop working in **covered employment**. These circumstances are described on the following pages.

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, behavioral health and substance abuse, prescription drug, dental and vision coverage. It does not include life insurance and Accidental Death & Dismemberment (“AD&D”). (See pages 107–112 for more information about COBRA.)

Retirement Between Ages 62 and 65

If you retire with an Early or Regular pension from the 32BJ Pension Fund, you and your eligible dependent(s) are eligible for hospital, medical,

*If your collective bargaining agreement or participation agreement has an earlier start date for contributions, you will be eligible on the contribution start date.

behavioral health and substance abuse, prescription drug and vision benefits under the Plan on a prospective basis if you meet all of the following requirements and enroll for coverage:

- your last day worked in **covered employment** is before age 65, but after age 62,
- you accumulated 15 combined years of pension service credit under the Building Service 32BJ Pension Fund,
- you worked in **covered employment** both 90 days immediately before your retirement and at least 36 months of the 60 months before your retirement (up to the first six months of time on Short-term Disability or Workers’ Compensation counts as work in **covered employment** when determining whether the 90 day and 36 month requirements are met), and
- you are receiving an Early or Regular retirement pension from the Building Service 32BJ Pension Fund.

You and your eligible dependent(s) will be eligible for Plan coverage until (i) you become eligible for Medicare, (ii) you reach age 65 or (iii) your pension is suspended, whichever occurs first. If a dependent is eligible or becomes eligible for Medicare due to age or disability, Medicare is primary and this Plan is secondary for each dependent eligible for Medicare. If your dependent does not enroll in both Medicare Part A and Part B coverage, because this Plan pays as secondary, you will be financially responsible for what Medicare would have paid, had your dependent properly enrolled. (See coordination of benefit rules on pages 97–100.) Those covered dependent(s) who are not eligible for Medicare continue to receive primary coverage from the Health Fund. However, once you are no longer eligible for benefits under the Plan, your dependent(s) also are no longer eligible for benefits under the Plan, subject to COBRA rights.

This benefit does not include dental,* LTD, life insurance or AD&D. If you would like dental coverage, you will have the option to elect and pay for it.

This extension of coverage is paid for by the Fund and will count toward the period for which you are entitled to continuing coverage under COBRA.

*Individuals who are approved for a disability pension from the Building Service 32BJ Pension Fund, who are also eligible for Early or Regular retirement between ages 62 and 65, will receive dental coverage as part of the health extension.

Fund-paid Health Extension

If all eligibility requirements are met, the Fund will pay for health coverage in the following situations, which are described further below: disability, which must have occurred while you were in **covered employment**, and arbitration, as described immediately after this section. All periods of Fund-paid Health Extension will count toward the period for which you are entitled to continuing coverage under COBRA. Coverage for Fund-paid Health Extension includes the Plan's hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision coverage. Life insurance and AD&D are continued only for the first six months. (See page 74 for the Life Insurance Disability Extension.)

To receive Fund-paid Health Extension coverage, you must complete the COBRA Continuation of Coverage Election Form you receive in the mail. If you fail to timely return the Election Form, you may lose eligibility for continuation of coverage under Fund-paid Health Extension and also under COBRA. The completed Election Form, along with all required documents (e.g., proof of disability), must be returned within the time period set forth in the COBRA Continuation of Coverage Election Form to:

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

Fund-paid Health Extension for Disability

You may continue to be eligible for up to 30 months of health coverage, provided you enroll for coverage, are unable to work and are receiving (or are approved to receive) one of the following disability benefits:**

- Short-term disability (limited to six months),
- Workers' Compensation (limited to six months if you are or become eligible for Medicare),
- Long-Term Disability ("LTD") under this Plan* (see pages 70–73), or
- Building Service 32BJ Pension Fund** Disability Pension.

* This includes those who would otherwise be approved for LTD, but are not because they are eligible for a pension greater than \$250 and those whose monthly LTD payments end due to eligibility for a pension benefit greater than \$250 a month.

** For employees of the Massachusetts Service Employees' Pension Fund and employees of the Health Fund and Thomas Shortman Training Fund, who previously worked for the Boston Building Service Employees' Trust Fund or the SEIU Property Services New England Training Fund, and who continue to work in Massachusetts, the SEIU Affiliates' Officers and Employees Pension Fund Disability Pension.

When any of the following events occur, your Fund-paid Health Extension for disability coverage will end:

- you elect to discontinue coverage,
- you work at any job,
- your LTD benefit is terminated because you are no longer totally disabled,
- 30 months have passed after you stopped working due to disability,
- your Workers' Compensation or short-term disability ends,
- you receive the maximum benefits under short-term disability or Workers' Compensation and are not eligible for LTD or a disability pension from the Building Service 32BJ Pension Fund, or
- you become eligible for Medicare as your primary insurer due to age or disability. Medicare is primary to this Plan after six months on short-term disability or Workers' Compensation benefits.

If a dependent is or becomes eligible for Medicare due to age or disability, Medicare is primary and this Plan is secondary for each dependent eligible for Medicare. If your dependent does not enroll in both Medicare Part A and Part B coverage, because this Plan pays as secondary, you will be financially responsible for what Medicare would have paid, had your dependent properly enrolled. (See coordination of benefit rules on pages 97–100.) Those covered dependent(s) who are not eligible for Medicare continue to receive primary coverage from the Health Fund. However, once you are no longer eligible for benefits under the Plan, your dependent(s) also are no longer eligible for benefits under the Plan, subject to COBRA rights.

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

To receive Fund-paid Health Extension for disability, you must apply and submit proof of disability no later than 60 days after the date coverage would have been lost, which is 90 days after you stopped working due to a disability. You apply by completing the COBRA Continuation of Coverage Election Form, which is mailed to you. You also can obtain a copy of this form from Member Services. The Plan reserves the right to require proof of your continued disability from time to time. Fund-paid Health Extension for disability coverage will count toward the period for which you are entitled

to continuing coverage under COBRA. (See pages 107–112 for COBRA information.)

Fund-paid Health Extension during Arbitration

If you are discharged* and the Union takes your grievance to arbitration seeking reinstatement to your job, your health coverage will be extended for up to six months or until your arbitration is decided, whichever occurs first. This extension of coverage will count toward the period for which you are entitled to continuing coverage under COBRA.

FMLA and Other State Leave

You may be entitled to take up to a 26-week leave of absence from your job under the Family and Medical Leave Act (“FMLA”). You may be able to continue health coverage paid by your **employer** during an FMLA leave. (See pages 105–106 for more information.) In addition, New York State, as well as other states or cities may offer family leave during which your employer may be required to continue health coverage. Consult your **employer** about leave requirements where you work and whether your **employer** provides health coverage during those periods.

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 health coverage. (See page 106 for more information.) This extension of coverage will count toward the period for which you are entitled to continuing coverage under COBRA.

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.

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

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: <ul style="list-style-type: none"> • 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 the 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: <ul style="list-style-type: none"> • Is not married, • Has the same principal address as the participant***, or as required under the terms of a “QMCSO” (see page 113), and • Is claimed as a dependent on your tax return.***

* 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 adopted dependent child will be covered from the date that the 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 page 18.) 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* or divorce.
- Your child's eligibility ends on the earlier of the date your child (i) no longer satisfies the requirements for a dependent child as described on page 15, or (ii) 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 children (including dependent children) ends 30 days after your death.

How to Enroll

Coverage for dependent(s) under the Plan is not automatic. You must enroll your eligible dependent(s) in the Plan.

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 14–16 to determine whether your dependent(s) are eligible for enrollment. You also will be required to submit documents proving relationship status including a marriage certificate (for your spouse), birth certificates (for your children) and, if applicable, proof of dependency (for your grandchildren, nieces and nephews for whom you are legal guardian). 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

* 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.

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 and submit all required documents. 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 page 18 for further details.)

The Plan will pay claims for eligible expenses for dependents only after the Fund has received the required enrollment 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.

Special Enrollment Rules

For participants working under a collective bargaining agreement that provides an annual open enrollment, depending upon the terms of that agreement, you may be permitted to enroll one or more of your dependent(s) (as defined on pages 14–16) in the same manner described above and under the section “How to Enroll” on pages 16–17 during the annual open enrollment period. After you make an election to enroll specific dependent(s) or to not enroll specific dependent(s), this election is generally fixed or locked in for the entire calendar year (January 1 to December 31). An exception applies if:

- you acquire a new dependent through marriage, birth, or adoption or placement for adoption,
- you have a non-enrolled dependent who loses coverage under another group health plan (unless coverage was terminated for cause or because your dependent failed to pay premiums on a timely basis), or the **employer** stops contributing towards your dependent(s) coverage under the other plan (if your dependent elected COBRA coverage, the entire COBRA coverage period must have been completed for this rule to apply), or

- 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.

In either of the first two circumstances, you may enroll your dependent during a special enrollment period that ends 30 days after the date of marriage, birth, adoption/placement, loss of other group health coverage or termination of **employer** contributions to other group health plan. If the special enrollment results from a loss of eligibility under Medicaid or CHIP, you may enroll your dependent within 60 days after the date of termination of such coverage. If the special enrollment results from a child becoming eligible for a state subsidy, you may enroll your dependent within 60 days after the date that such eligibility is determined.

There will be an open enrollment period before the end of each calendar year in which you can make a change in your enrolled dependent(s), or enroll a dependent(s) if none was previously enrolled (or if your previously enrolled dependent(s) ceased to become eligible during the calendar year) for the next calendar year. If you do not take any action during the open enrollment period, your existing election will remain in effect for the next calendar year.

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 after 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. Please note, however, no benefits will be paid until you submit the required forms and supporting documentation to the Fund. 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 15–16.

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. Please note that knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution.

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, you must notify the Fund within 60 days after 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 could result in the loss of a right to elect health continuation under COBRA. Failure to notify the Fund of your dependent becoming eligible for the state subsidy could lead to a delay or denial in the payment of health benefits.

What Benefits Are Provided

The Fund provides a comprehensive program of benefits, including hospital, medical, behavioral health and substance abuse, prescription drug, dental, vision, life insurance, accidental death and dismemberment and pensioner death benefits (only for Building Service 32BJ Pension Fund pensioners). The Fund also provides long-term disability benefits for Metropolitan Plan participants. Also, through Guardian, it provides short and long-term disability benefits for Suburban Plan participants. Each of these benefits is described in the sections that follow.

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

Annual out-of-pocket maximum on in-network benefits. There is an annual out-of-pocket maximum on **in-network** hospital, medical, behavioral health and substance abuse and pharmacy benefits. In 2020, your annual

out-of-pocket maximum is \$8,150 and your family's annual out-of-pocket maximum is \$16,300.* If you have other family members enrolled in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

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

Your annual out-of-pocket maximum for individual **in-network** medical benefits in 2020 is \$6,350 and your family's annual out-of-pocket maximum for **in-network** medical benefits is \$12,700. After a family has spent \$12,700 in out-of-pocket costs for **in-network** medical benefits, regardless of how much each family member paid in out-of-pocket costs for **in-network** medical benefits, there are no additional out-of-pocket costs for any additional **in-network** medical benefits during the calendar year.

Your annual out-of-pocket maximum for individual **in-network** prescription drug benefits is \$1,800 and your family's annual out-of-pocket maximum for **in-network** prescription drug benefits is \$3,600. After a family has spent \$3,600 in out-of-pocket costs for **in-network** prescription drugs, regardless of how much each family member paid in out-of-pocket costs for **in-network** prescription drugs, there are no additional out-of-pocket costs for any additional **in-network** prescription drugs during the calendar year.

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

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

*Expenses that do not count toward the annual **in-network** out-of-pocket maximum:*

- Premiums,
- **Out-of-network deductibles,**
- **Out-of-network co-insurance,**
- Balance billing, and
- Expenses for non-covered services.

* The Department of Health and Human Services ("HHS") examines the limits annually and may increase them based on the premium adjustment percentage (an estimate of the average change in health insurance premiums). The Plan will change its out-of-pocket maximums each January 1 to match HHS' limits. However, the Plan's prescription drug maximum out-of-pocket will remain fixed at \$1,800/individual and \$3,600/family. Increases in HHS' limits will be assigned entirely to the Plan's medical out-of-pocket maximum.

Hospital, Medical, Behavioral Health and Substance Abuse Benefits

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

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

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

* 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 Empire 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.

Conditions for Hospital and Medical Expense Reimbursement

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

Empire ID Card

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

Nurses Healthline

This is a free 24-hour information line for Empire members. When you call, you can either speak to a registered nurse or select from over 1,100 audio-taped messages in English or Spanish on a wide variety of topics. If you do not speak English or Spanish, interpreters are available through a language line. You may find it helpful to speak to a registered nurse when you need help assessing symptoms, deciding whether a trip to the emergency room is necessary or understanding a medical condition, procedure, prescription or diagnosis. You can reach the Nurses Healthline at 1-877-825-5276.

LiveHealth Online. LiveHealth Online is a convenient way to have a face-to-face interaction online with a **doctor** when you need care but can't reach your regular **doctor** after hours, on holidays or on weekends. LiveHealth Online should be used for non-urgent medical situations such as colds, sore throats, or the flu. LiveHealth Online from Empire BlueCross BlueShield is available 24/7 and the **copay** for this service is the same as for an **in-network participating doctor/provider**. The online **doctor** can diagnose, treat and, if state regulations allow, prescribe medications.

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

In-Network Preferred Facilities Have the Lowest Out-of-Pocket Costs

When you use **in-network providers**—including hospitals and doctors—your out-of-pocket costs will be lower than if you use **out-of-network providers**.

In addition, **copays** for **in-network** care can depend on the provider you select. The 32BJ Health Fund has designated certain facilities as **Preferred** and **Non-Preferred**. If you use **Preferred facilities**, you will have lower **copays** than if you use **Non-Preferred facilities**. And, if you use **5 Star Centers**, you will have no **copays** for office visits. (See the Schedule of Covered Services on pages 29–43.)

This means you will have the lowest out-of-pocket costs if you use **Preferred in-network providers** and **5 Star Centers**. Using either **Non-Preferred in-network providers** or **out-of-network providers** will cost you more.

A list of **5 Star Centers** and **Preferred** and **Non-Preferred in-network** hospitals and facilities is available on the Plan's website at www.32bjfunds.org. You may also call Member Services at 1-800-551-3225 for assistance.

How to Stay In-Network

In-network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by an **in-network provider**.

The **in-network provider** will assess your medical needs and advise you on appropriate care. You will have lower costs or no costs for covered services. In addition, there are no **deductibles** or **coinsurance** to pay, and no claims to file or track. (See the Schedule of Covered Services on pages 29–43 for more information.)

When your **in-network provider** refers you to another provider for services or recommends treatment in a hospital-owned facility, you should be sure to check whether that other provider or hospital-owned facility is **in-network** and is **Preferred** or **Non-Preferred**. You may ask your **doctor** or surgeon, but they do not always know whether hospital-owned facilities are **Preferred**. You may also call Member Services at 1-800-551-3225 for assistance.

When You Go Out-of-Network

You will pay more when you use an out-of-network provider.

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 not the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service, commonly referred to as the usual, customary and reasonable (“UCR”) rate. When you go **out-of-network**, the **allowed amount** is roughly equivalent to 110% of the Medicare reimbursement rate but varies based on the procedure.

Amounts above the **allowed amount** are not eligible for reimbursement from the Plan and are your responsibility to pay. This is in addition to any **deductibles** and required **co-insurance**.

IMPORTANT NOTE: Some services are not covered when you use an out-of-network provider. (See pages 29-43 for additional information.)

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

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

Types of Out-of-Pocket Costs for Out-of-Network Benefits

Annual deductible. Your individual annual **deductible** is \$250 and your family annual **deductible** is \$500. If you have other family members enrolled in the Plan, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.

Expenses that do not count toward the deductible:

- **in-network copays**,
- charges that exceed the **allowed amount** for eligible **out-of-network** expenses,
- penalty amounts that you pay because you failed to obtain pre-authorization for a hospital stay or meet any other pre-authorization requirements, and
- charges excluded or limited by the Plan. (See pages 44–50.)

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 copays**,
- **deductibles**,
- charges that exceed the **allowed amount** for eligible **out-of-network** expenses,

- amounts that you pay because you failed to obtain pre-authorization for a hospital stay or meet any other pre-authorization requirements, and
- charges excluded or limited by the Plan. (See pages 44–50.)

If you decide to stay with your choice of an **out-of-network provider**, you may have significant out-of-pocket costs. Although the Plan pays 70% of the **allowed amount**, the **out-of-network provider** may charge you more than the **allowed amount**.

Example of What You Could Pay When You See a Non-Participating Provider

Charges by **non-participating providers** vary, and are usually more than the **allowed amount**. Assuming services are determined to be **medically necessary**, below is an example, as an illustration only, of the amount you may owe when you use a **non-participating provider**:

Provider Charge for Surgery	\$17,000
Allowed amount for Surgery	\$1,450
You pay the deductible	\$250
You also pay 30% of the allowed amount after your deductible (co-insurance)	$\$1,450 - \$250 = \$1,200$ $\$1,200 \times 30\% = \mathbf{\$360}$
You also pay the difference between the allowed amount and the provider charge	$\$17,000 - \$1,450 = \mathbf{\$15,550}$
Total Amount You Owe	$\\$250 + \\$360 + \\$15,550 = \\$16,160$
Plan pays 70% of the allowed amount after your deductible	$\$1,450 - \$250 = \$1,200$ $\$1,200 \times 70\% = \840
Total Amount the Plan Pays	\$840

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

Your Responsibilities When You Use an Out-of-Network Provider

You must file claims yourself when you use an **out-of-network provider**.

You must request pre-authorization for certain services when you use an **out-of-network provider**.

Failure to pre-authorize will result in a financial penalty, which you will be responsible for paying.

Benefit Maximums

There are no lifetime limits on hospital, medical, behavioral health and substance abuse benefits. However, there are limits on how much (and how often) the Plan will pay for certain services, even when the services are covered. If there are limits on a particular service, those limits are described in the Schedule of Covered Services. (See pages 29–43.)

Coverage When You Are Away from Home

When you are outside of the area covered by the POS **network** (see footnote 8 on page 130), you are covered for all **medically necessary** care on an **in-network** basis with a **copay** when using a local BlueCross BlueShield **participating provider**.

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 a length of stay not in excess of 48 hours (or 96 hours).

Pre-authorization for Hospital, Medical, Behavioral Health and Substance Abuse

When you use a **network provider**, in most instances the provider will do the pre-authorization for you. However, if circumstances prevent your provider from obtaining pre-authorization, e.g., you request and receive services on a weekend or a holiday, you may be responsible for paying for the entire cost of the service.

When you use an **out-of-network provider**, it is your responsibility to have the required services pre-authorized. This means that you have to contact Empire BlueCross BlueShield as shown on this page and page 29, or make sure that your provider has done so. Failure to pre-authorize will result in a financial penalty, which you will be responsible for paying.

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

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

Type of Care that Requires Pre-authorization	When You Must Call
<ul style="list-style-type: none"> • Air ambulance⁹ (non-emergency) • Bone Density and Echo Stress Tests • Genetic testing • Intensive outpatient services for behavioral health or substance abuse • MRI or MRA scans • Percutaneous Coronary Intervention (“PCI”), Cardiac Catheterization and Vascular Ultrasound • PET, CAT and nuclear imaging studies • Physical and occupational therapy • Prosthetics/orthotics or durable medical equipment (rental or purchase) • Radiation therapy • Sleep studies 	As soon as possible before you receive care.
<ul style="list-style-type: none"> • Surgical procedures (inpatient and outpatient) 	Two weeks before you receive surgery or as soon as care is scheduled.
<p>Inpatient:</p> <ul style="list-style-type: none"> • Scheduled hospital, behavioral 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.
<ul style="list-style-type: none"> • Maternity admissions • Emergency admissions 	Within 48 hours after delivery or admission.
<ul style="list-style-type: none"> • 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 pages 130–131.

How pre-authorization works. Empire BlueCross BlueShield will review the proposed care to pre-authorize the admission or number of visits (as applicable) and will approve or deny coverage for the procedure based on medical necessity. They will then send you a written statement of approval or denial within three business days after they have received all necessary information. In urgent care situations, Empire BlueCross Blueshield will make its decision within 72 hours after they have received all necessary information and notify you of their decision in writing. (For more information, see pages 81–84.)

If you do not pre-authorize the care listed above within the required time frames, benefit payments will be reduced by \$250 for each admission, treatment or procedure. If the Plan determines the admission or procedure was not medically necessary, no benefits are payable.

Schedule of Covered Services

The following tables show different types of health care services, how they are covered in a **Preferred hospital or facility** versus a **Non-Preferred hospital or facility, in-network** versus **out-of-network**, and whether there are any limitations on their use.

In the Hospital¹ and Other Inpatient Treatment Centers*

Benefit	In-Network Facility	Out-of-Network Hospital or Facility	Limitations
Semi-private room and board* (for obstetrical care, hospital stays are covered for at least 48 hours following normal delivery, or at least 96 hours following cesarean section)	Plan pays 100% after \$100 copay per admission at Preferred hospitals and \$1,000 copay per admission at Non-Preferred hospitals .**	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	
In-hospital services of doctors and surgeons and other professionals			
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			
Medically necessary special diet and nutritional services while in the hospital			
Inpatient lab and radiology services (including hi-tech radiology)			

In the Hospital¹ and Other Inpatient Treatment Centers* (continued)

Benefit	In-Network Facility	Out-of-Network Hospital or Facility	Limitations
Bariatric surgery*	Plan pays 100% if surgery is conducted by a designated surgeon at Mount Sinai Saint Luke's Hospital ("MSSLH") in New York City. For surgery with non-designated surgeons or at another Preferred Blue Distinction Hospital in the Empire network , the Plan pays up to 100% of the allowed amount that it would have paid MSSLH and the member is responsible for the amount in excess of the allowed amount up to the annual in-network out-of-pocket maximum. For surgery at a Non-Preferred Blue Distinction hospital , the Plan pays up to 100% of the allowed amount that it would have paid MSSLH and the member is responsible for the amount in excess of the allowed amount up to the annual in-network out-of-pocket maximum or \$1,000, whichever is greater.	Not Covered	Only covered at Blue Distinction Hospitals in the Empire network . Call Member Services for information about the 32BJ Bariatric Program.
Transplant surgery*	Plan pays 100% after \$100 copay per admission at Preferred hospitals and \$1,000 copay per admission at Non-Preferred hospitals .		Kidney and lung transplants are covered in-network only at any BlueCross BlueShield participating hospital.
Lifetime travel maximum for a transplant	Up to \$10,000 per transplant.		Other transplants are covered only at Blue Distinction Centers of Medical Excellence. ¹ Call Member Services for a list of Blue Distinction Centers of Medical Excellence.

* Pre-authorization required for all inpatient admissions.

** If you are admitted as an in-patient to a **Non-Preferred in-network hospital or facility** due to an **emergency**, you will have a \$100 **copay**.

For definitions of various facilities and further details, see footnote 1 on pages 127–128.

Footnotes and asterisks are on the bottom of pages 31 and 32.

In the Hospital¹ and Other Inpatient Treatment Centers* (continued)

Benefit	In-Network Facility	Out-of-Network Hospital or Facility	Limitations
Total Joint Replacement (hip and knee)*	Plan pays 100% if surgery is conducted by a designated surgeon at a facility which is part of the Mount Sinai Health System ("MSHS") hospital network in New York City. For surgery with non-designated surgeons or at another in-network facility: Plan pays up to 100% of the allowed amount that it would have paid MSHS. At Preferred hospitals , the member is responsible for the amount in excess of the allowed amount up to the annual in-network out-of-pocket maximum. At Non-Preferred hospitals , the member is responsible for the amount in excess of the allowed amount up to the annual in-network out-of-pocket maximum or \$1,000, whichever is larger.	Plan pays 70% of the allowed amount and member pays 30% after the deductible and any charges above the allowed amount .	Call Member Services for information about the 32BJ Joint Replacement Program.
Gender Reassignment Surgery	Plan pays 100% after \$100 copay per admission at Preferred hospitals and \$1,000 copay per admission at Non-Preferred hospitals .	Plan pays 70% of the allowed amount , the member pays 30% after the deductible and any charges above the allowed amount .	
Skilled nursing care facility ^{4*}	Plan pays 100%	Not Covered	In-network only. Covered up to 60 days per calendar year.
Hospice care facility ^{5*}	Plan pays 100%	Not Covered	In-network only.

* Pre-authorization required.

For definitions of various facilities and further details, see footnote 1 on pages 127–128, footnote 4 on page 128 and footnote 5 on page 129.

Emergency Care

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Emergency room ⁸ ("ER") in a hospital	Plan pays 100% after \$100 copay for first two visits; then \$200 copay per visit.	Plan pays 100% after \$100 copay for first two visits; then \$200 copay per visit. In an emergency , if you use out-of-network providers you may be responsible for deductibles and co-insurance and you may be held responsible if the out-of-network provider's charges exceed the allowed amount .	ER copay increases after the 2nd ER visit in a calendar year. Follow-up visits to the ER are not covered (e.g., stitch removal).
Urgent care center	Plan pays 100% after \$40 copay	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	If the urgent care center bills your visit as an emergency room visit, you will pay the ER copay .
Ambulance service ⁹	Plan pays 100%		Not covered if after transport you do not receive treatment services.

See footnote 8 on page 130 and footnote 9 on pages 130–131.

Outpatient Treatment Facilities

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Presurgical Testing	Plan pays 100%	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Testing must be performed within 21 days of surgery.
Surgery ² and care related to surgery (including operating and recovery rooms)*	Plan pays 100% after copay based on where service is provided:	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	The following services only have one copay per calendar year: chemotherapy, radiation therapy and hyperbaric oxygen treatment.
Diagnostic procedures (such as endoscopies) and x-rays (not including hi-tech – see below)	If in outpatient hospital setting: \$75 copay for Preferred hospitals and \$250 copay for Non-Preferred hospitals .		
Radiation therapy*	If in an office or Freestanding Facility : \$0 copay .		
Chemotherapy*			
Hyperbaric Oxygen Treatment*			
Kidney dialysis ³ *			
Hi-tech imaging (CAT, MRI, MRA,PET, and nuclear imaging)*	Plan pays 100% after \$75 copay at Preferred hospitals or independent facilities, or \$250 copay at Non-Preferred hospitals .	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	
Blood tests	Plan pays 100%	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	

*Pre-authorization required. See footnote 2 on page 128 and footnote 3 on page 128.

Care in the Doctor's Office

Benefit	In-Network	Out-of-Network	Limitations
Office visits	Plan pays 100% for office visits with a 5 Star Center Provider.	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Limited to 12 treatment visits per calendar year, plus up to two testing visits per calendar year for allergy care.
Specialist visits			
Allergy care			
Hearing exams			
Chiropractic visits			
Podiatric care, including routine foot care	Plan pays 100% after \$40 copay for office visits with other in-network providers .		Limited to ten visits per calendar year. Excluding routine orthotics. Medically necessary orthotics (shoe inserts) limited to one pair per adult and two pairs per child (under 19) per calendar year.
Acupuncture visits		Not Covered	In-network only. Limited to 20 visits per calendar year.
Surgery in a doctor's office ²	Plan pays 100%	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	
Diagnostic procedures, lab and x-rays			

See footnote 2 on page 128.

Home Health Services

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

See footnote 3 on page 128, footnote 5 on page 129, footnote 6 on page 129 and footnote 7 on page 130.

Behavioral Health and Substance Abuse Care

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Inpatient admission*	Plan pays 100% after \$100 copay per admission at Preferred hospitals and \$1,000 copay per admission at Non-Preferred hospitals.**	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	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 are not covered. Additionally, 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.
Physician/behavioral health professional office visits	Plan pays 100% for office visits with a 5 Star Center Provider. Plan pays 100% after \$40 copay for LiveHealth Online and \$20 copay for office visits with other in-network providers .		
Outpatient hospital facility*	Plan pays 100% after \$75 copay at Preferred hospitals , or \$250 copay at Non-Preferred hospitals .		

* Pre-authorization required.

** If you are admitted as an in-patient to a **Non-Preferred in-network hospital or facility** due to an **emergency** you will have a \$100 **copay**.

Preventive Medical Care*

Benefit	In-Network	Out-of-Network	Limitations
Preventive health services, including annual physical exam and screening for colorectal, lung, skin cancer, hepatitis B and C, osteoporosis and obesity	Plan pays 100% after copay based on where service is provided:	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Annual exam and covered preventive health services based on age, sex and health risk factors. Annual exams are covered once per calendar year.
Well-woman care, which may include an annual well-woman exam and screening for cervical cancer, pregnancy related screenings, and reproductive health screenings	If in an office or independent non-hospital owned facility – \$0 copay . If in an outpatient Preferred hospital setting – \$75 copay . If in an outpatient Non-Preferred hospital setting – \$250 copay .		Preventive procedures (e.g., mammogram, colonoscopy) at • \$0 copay /visit at an office or independent non-hospital owned facility. • \$75 copay /visit at a Preferred in-network hospital or hospital based facility. • \$250 copay /visit at a Non-Preferred in-network hospital or hospital based facility.
Well-child care ¹⁰ provides for regular check-ups and preventive health services, and immunizations identified in footnote ¹⁰			Well-child visits are subject to the frequency limits listed below and preventive health services based on age: Number of Visits/Age Range: 1 exam at birth/Newborn 6 visits/ Under 1 7 visits/ 1–4 yrs. old 7 visits/ 5–11 yrs. old 6 visits/ 12–17 yrs. old 2 visits/ 18–19 yrs. old
Routine immunizations – all ages (includes travel immunizations)	Plan pays 100% – \$0 copay .	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Immunizations based on age and health risk factors.
Nutritional counseling			Unlimited

The Plan covers certain preventive care services when using an **in-network provider**. These services will be covered with a \$0 **copay** in some settings. Other settings will have a **copay** for **covered services**. 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 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.

Reproductive Health Services

Benefit	In-Network	Out-of-Network	Limitations
Reproductive health office visits and counseling for contraceptive measures and devices (such as tubal ligation, IUD insertion and diaphragm fittings)	No copay Plan pays 100%	Plan pays 70% of the allowed amount and member pays 30% after the deductible and any charges above the allowed amount .	
Vasectomy (excludes reversals)	Plan pays 100% after copay based on where service is provided: If in an office or independent non-hospital owned facility – \$0 copay .		
Abortion, includes elective and non-elective procedures	If in an outpatient Preferred hospital setting – \$75 copay . If in an outpatient Non-Preferred hospital setting – \$250 copay .		
Infertility testing			Infertility testing limited to once per calendar year.
Infertility treatment	Not Covered	Not Covered	No coverage for treatment of infertility.

See footnote 10 on page 131. (Footnotes continue on the following page.)

Pregnancy, Maternity Care and Newborn

Benefit	In-Network	Out-of-Network	Limitations
Office visits for prenatal and postnatal care from a doctor or certified nurse-midwife, ¹² including diagnostic procedures	Plan pays 100% for office visits with a 5 Star Center Provider. Plan pays 100% after initial \$40 copay . No copay for first postnatal visit.	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Copays for prenatal visits are limited to one copay per pregnancy, upon confirmation of pregnancy.
Newborn in hospital nursery	Plan pays 100%		
Obstetrical care* in hospital	Plan pays 100% after \$100 copay for admission at a Preferred hospital and \$1,000 copay for admission at a Non-Preferred hospital .	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	
Birthing Center	Plan pays 100% after \$100 copay for admission at a Preferred hospital and \$1,000 for admission at a Non-Preferred hospital .	Not Covered	No coverage for out-of-network birthing centers.
Home birth with a certified nurse-midwife ¹²		Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Prior authorization is required for use of a non-participating nurse midwife for home birth.
A home health care visit	Plan pays 100%	No out-of-network benefit.	One (1) home health care visit within 24 hours of discharge, only if the mother leaves the hospital before the 48 or 96 hour period indicated under hospital benefits and provider issues script for visit.

*Pre-authorization required.

See footnote 11 on page 131 and footnote 12 on page 131.

Pregnancy, Maternity Care and Newborn (continued)

Benefit	In-Network	Out-of-Network	Limitations
Circumcision of newborn males	Plan pays 100% after copay based on when and where service is provided: If before discharge: \$0 copay . If, after discharge: – in an office setting: – \$0 copay 5 Star Center Provider – \$40 copay In-network provider . – in a hospital setting: – \$75 copay Preferred hospital – \$250 copay Non-Preferred hospital .	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	

Physical, Occupational, Speech or Vision Therapy (including rehabilitation)¹³

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Acute inpatient rehabilitation stays*	Plan pays 100% after \$100 copay per admission at a Preferred hospital and \$1,000 copay per admission at a Non-Preferred hospital .	Plan pays 70% of the allowed amount and the member pays 30% after the deductible and any charges above the allowed amount .	Covered up to 30 days per calendar year.
Doctor's office Outpatient facility	Plan pays 100% for office visits with a 5 Star Center Provider. Plan pays 100% after \$40 copay for office visits. Plan pays 100% after \$75 copay at Preferred hospitals , or \$250 copay at Non-Preferred hospitals .	Not Covered	In-network only. Covered 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-authorization required.

See footnote 13 on page 132.

Durable Medical Equipment and Supplies¹⁴

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 and orthotics* (e.g., foot inserts)	Plan pays 100%	Not Covered	In-network** benefit only. Foot inserts are covered only for non-routine foot conditions—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% when using a durable medical equipment provider.***	Not Covered	In-network** benefit only. If diabetic supplies are ordered under the Prescription Drug Benefit, see pages 51–52 for applicable copay .
Wigs	Plan pays 100%	Plan pays 70% of the allowed amount and the member pays 30% of the allowed amount after the deductible and any charges above the allowed amount .	Covered following chemo or radiation therapy and in other limited circumstances, such as alopecia, lupus, burns and wounds of the scalp.
Nutritional supplements ¹⁵ that require a prescription (formulas, including infant formulas, and modified solid food products)	Plan pays 100% when using a durable medical equipment provider.***	Plan pays 70% of the allowed amount and the member pays 30% of the allowed amount after the deductible and any charges above the allowed amount .	Not covered under the Prescription Drug Benefit.

Footnotes and asterisks are at the end of the table on page 43.

Durable Medical Equipment and Supplies¹⁴ (continued)

Benefit	In-Network	Out-of-Network	Limitations
Hearing aids	Plan pays 100%	Not Covered	In-network** benefit only through a durable medical equipment provider. Coverage is dependent on medical necessity . The Plan pays for a level three hearing aid. The participant has the option of paying the difference between what the Plan pays and the cost of more technologically advanced hearing aids. Up to two hearing aids per lifetime.

* Pre-authorization required.

** Durable medical equipment providers may not be the same as hospital/medical providers. Contact Member Services to ensure you receive your durable medical equipment from an **in-network** durable medical equipment provider.

*** For a list of durable medical providers, contact Member Services.

See footnote 14 on page 132 and footnote 15 on page 132.

Dental Care Covered Under Medical Benefit*

Benefit	In-Network	Out-of-Network	Limitations
Surgical removal of impacted wisdom teeth only	Plan pays 100% after copay .		
Repair to natural teeth after injury	If in an office or independent non-hospital owned facility—\$0 copay . If in outpatient Preferred hospital setting—\$75 copay . If in outpatient Non-Preferred hospital setting—\$250 copay .	Plan pays 70% of the allowed amount and the member pays 30% of the allowed amount after the deductible and any charges above the allowed amount .	Only within 12 months of injury to sound natural teeth.

* Dental care is also covered under the Plan's dental benefit described on pages 57–68 of this SPD. When a dental procedure is eligible for coverage under both your hospital/medical plan and the dental plan, your hospital/medical plan will always be the primary payor.

Excluded Hospital, Medical, Behavioral Health and Substance Abuse Expenses

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

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

- expenses incurred before the patient's coverage began or after the patient's coverage ended
- treatment that is not **medically necessary**
- cosmetic treatment¹⁶
- technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are experimental, investigative, obsolete or ineffective.¹⁷ 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
- 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, and religious healing, including services, and naturopathic, naprapathic, or homeopathic services or supplies
- expenses for memberships in, or visits to, health clubs, exercise programs, gymnasiums or other physical fitness facilities
- commercial weight loss programs, e.g., Weight Watchers and Jenny Craig
- operating room fees for surgery, surgical trays and sterile packs done in a non-state-licensed facility including the **doctor's** office

- 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
- 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
- services for treatment of intellectual disabilities
- 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 any licensed provider without an independent license in that scope of care
- 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
- services provided for Applied Behavioral Analysis ("ABA") therapy
- ambulette
- the following specific preventive care services:
 - screening tests done at your place of work at no cost to you
 - physicals for pre-employment, school, summer camp or other related activities of this nature which are in addition to physicals or well child visits as described in the Schedule of Covered Services
 - free screening services provided 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 124.)
 - use of the emergency room for follow-up visits
- the following specific maternity care services:

See footnote 16 on page 133 and footnote 17 on page 133.

- 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 surgery¹⁶ or any related hospital expenses or treatment of any related complications
 - hospital services received in clinic settings that do not meet Empire’s definition of a hospital or other covered facility
 - bariatric surgery at a facility that is not a Blue Distinction Hospital within the Empire **network**
- the following specific outpatient hospital care expenses:
 - with the exception of chemotherapy, routine medical care including, but not limited to, inoculation, vaccination, drug administration or injection, unless performed in a hospital clinic setting
 - collection or storage of your own blood, blood products or semen
- all excluded **out-of-network** services
 - the following specific equipment:
 - air conditioners or purifiers
 - humidifiers (except when needed with c-pap machine) or dehumidifiers
 - exercise equipment
 - swimming pools
 - skilled nursing facility care that primarily:
 - gives assistance with daily living activities
 - is for rest or for the aged
 - is convalescent care
 - is sanitarium-type care
 - is a rest cure
 - the following specific home health care services:
 - custodial services, including bathing, feeding, changing or other services that do not require skilled care
 - the following specific physical, occupational, speech or vision therapy services:
 - therapy to maintain or prevent deterioration of the patient’s current physical abilities
 - treatment for developmental delay, including speech therapy
 - the following specific vision care services:
 - expenses for surgical correction of refractive error or refractive keratoplasty procedures including, but not limited to, radial keratotomy (“RK”), photo-refractive keratotomy (“PRK”) and laser in situ keratomileusis 21 (“LASIK”) and its variants
 - eyeglasses, contact lenses and the examination for their fitting except following cataract surgery. However, see Vision Care Benefits on pages 68–70 to find out how eyeglasses and contact lenses may be covered under the vision benefit.
 - routine vision care (See Vision Care Benefits on pages 68–70 for coverage information.)

See footnote 16 on page 133.

- the following services that may be covered elsewhere under the Plan:
 - dental treatment, except surgical removal of impacted teeth or treatment of sound natural teeth injured by accident if treated *within 12 months* of the injury; however, see Dental Benefits on pages 57–68 and pages 134–141
 - all prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, vitamin therapy, appetite suppressants, or any other type of medication, unless specifically indicated. However, see Prescription Drug Benefits on pages 51–56 to find out how prescription drug expenses may be covered.
 - false teeth (not covered under hospital/medical, but may be covered under dental.) (See Dental Benefits on pages 57–68 and pages 134–141.)
- the following miscellaneous health care services and expenses:
 - services performed in nursing or convalescent homes, institutions primarily for rest or for the aged, rehabilitation facilities (except for physical therapy), spas, sanitariums, or infirmaries at schools, colleges or camps
 - injury or sickness that arises out of any occupation or employment for wage or profit for which there is Workers’ Compensation or occupational disease law coverage (for information about subrogation of benefits, see pages 101–104)
 - injury or sickness that arises out of any act of war (declared or undeclared) or military service of any country
 - injury or sickness that arises out of a criminal act (other than domestic violence) by the covered person, or an intentionally self-inflicted injury that is not the result of mental illness
 - expenses for services or supplies for which a covered person receives payment or reimbursement from casualty insurance or as a result of legal action, or expenses for which the covered person has already been reimbursed by another party who was responsible because of negligence or other tort or wrongful act of that party (for information about subrogation of benefits, see pages 101–104)
 - expenses reimbursable under the “no-fault” provisions of a state law
 - services covered under government programs, except under Medicare, Medicaid or where otherwise noted
 - any hospital or **physician** care received outside of the U.S. that is not **emergency** care
 - government hospital services, except specific services covered under a special agreement between Empire and a governmental hospital or services in United States Veterans’ Administration or Department of Defense hospitals for conditions not related to military service
 - treatment or care for temporomandibular disorder or temporomandibular joint disorder (“TMJ”) syndrome
 - services such as laboratory, X-ray and imaging, and pharmacy services from a facility in which the referring **doctor** or his or her immediate family member has a financial interest or relationship
 - services given by an unlicensed provider or performed outside the scope of the provider’s license
 - charges for services a relative provides
 - charges that exceed the maximum **allowed amount** or visits that exceed the annual or lifetime 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

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 or for services performed at the following out-of-network facilities:**

- kidney dialysis
- bariatric surgery performed at a hospital that is not a Blue Distinction Center of Medical Excellence
- transplant surgery for bone marrow, liver, heart and pancreas performed at a hospital that is not a Blue Distinction Center of Medical Excellence
- transplant surgery for a kidney or lung transplant performed at a non-participating BlueCross BlueShield hospital
- skilled nursing facility
- home health care
- hospice care facility
- home infusion therapy
- birthing centers
- outpatient physical, occupational speech, and vision therapy
- durable medical equipment
- prosthetics/orthotics
- medical supplies
- hearing aids

Prescription Medication Benefit

Your prescription medication benefit is administered by CVS Caremark. The list of medications that are covered by your Plan is known as a “formulary.” The formulary includes specific generic, brand and specialty medications. Your Plan’s formulary is mandatory generic, which means, in most instances, when a generic is available, if the pharmacy dispenses a brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand name **copay**.

Copays for covered medications:

	Up to a 30-day supply	Up to a 90-day supply	Non-Participating Pharmacy
Generic Medications	\$10 copay	\$20 copay	Covered up to what the Fund would pay a participating retail pharmacy less your copay .
Brand and Specialty Medications	\$30 copay	\$60 copay	Covered up to what the Fund would pay a participating retail pharmacy less your copay .

Notes: No **copay** required for contraceptive prescriptions and certain preventive over-the-counter medications prescribed for you. (See Eligible Drugs on pages 55–56.) In addition, if the cost of the medication is less than the **copay**, you pay the cost of the medication.

If your **doctor** prescribes a formulary brand-name medication and selects “Dispense As Written” (“DAW”) when an “A”-rated generic equivalent medication is available, you will have to pay the **copay** (\$30 or \$60) and the difference in cost between the brand-name and the generic medication. Brand-name medications can be very costly so always ask your **doctor** to prescribe generic medications when possible.

If you or your **doctor** want to know whether a drug is on the formulary, you can call CVS/Caremark at 1-877-765-6294 or visit www.Caremark.com.

Remember, your maximum annual out-of-pocket limit for **in-network** prescription medication **copays** is \$1,800 for an individual and \$3,600 for a family.* If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There are no other **copays** for **in-network** prescription medications for the remainder of the calendar year once you reach this annual maximum.

5 Star Wellness Program

Members and their dependent(s) with diabetes, asthma, heart disease, chronic obstructive pulmonary disease (“COPD”), stroke, peripheral artery disease (“PAD”) and hypertension who receive their primary care services** from 5 Star Center Providers will pay a **copay** of \$5 per prescription for a 30-day supply or \$10 per prescription for a 90-day supply when filled as described below. For more information, or to see if you are eligible, call Member Services at 1-877-299-1636 or email us at 5StarCenterTeam@32bjfunds.com.

There Are Several Ways to Get Your Prescriptions Filled

For Short-term Medications

When you need to take a prescription for a period of no more than 60 days, you can have your prescription filled at a participating pharmacy. You may receive up to a 30-day supply plus one refill of up to a 30-day supply.

For Maintenance Medications

If you need to take a maintenance medication on an ongoing basis for more than 60 days, there are two ways you can fill your prescription:

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

If you fill your maintenance medication prescription elsewhere after the first 60 days, it will be covered as if it were filled at a non-participating pharmacy.

* The Department of Health and Human Services (“HHS”) examines the limits annually and may increase them based on the premium adjustment percentage (an estimate of the average change in health insurance premiums). The Plan will change its out-of-pocket maximums each January 1 to match HHS’ limits; however, the prescription drug portion will remain fixed.

** This requirement does not apply to **emergency** or urgent care services or services that are not available from a 5 Star Center Provider.

To use the CVS Caremark Mail Service, call the CVS Caremark Customer Care team at 1-877-765-6294 or go to the website (www.Caremark.com).

For Specialty Medications*

Your pharmacy benefits cover only specialty medications that are on the CVS Caremark formulary and that are filled at:

1. Any CVS retail pharmacy, or
2. Through the CVS Caremark Specialty Pharmacy.

Note, however, that HIV medications may be filled at any participating pharmacy, not just CVS pharmacies.

There is no coverage for specialty medications that are not on the CVS Caremark formulary. If your specialty medication is on the formulary, you must fill your prescription at a CVS retail pharmacy or through the CVS Caremark Specialty Pharmacy (except as noted above for HIV medication).

Prescription Plan Coverage Management Programs

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

Prior Authorization

Certain medications on the Plan’s formulary require Prior Authorization before your prescription will be covered under the Plan. Drugs subject to Prior Authorization include those products that are commonly subject to overuse, misuse or off-label use, subject to significant safety concerns, or are very expensive.

The Prior Authorization Program is administered by CVS Caremark to determine whether your use of certain medications meets the Plan’s

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

conditions for coverage and CVS Caremark's clinical guidelines for use of the specific drug. The prescriber will need to contact CVS Caremark's Prior Authorization Department to provide the necessary clinical information to determine the appropriateness of the medication for the member before the prescription can be filled. Typically, when a medication is approved under the Prior Authorization Program, the approval is good for a specific period.

Step Therapy

The Step Therapy Program ensures the medications you receive are safe and cost-effective. Under the Step Therapy Program, you may first be required to use a generic or alternate brand medication. This helps to keep prescription costs low. When you present a prescription for certain medications to your pharmacist, CVS Caremark will check to see if you've tried a generic or alternate medication to treat the same condition. If your prescription history shows you already used a generic or alternate brand medication, your prescription may be approved and filled as written. If there is no history of your use of a generic or alternate brand medication, the pharmacist will receive a message for the prescriber to call a toll free number for more information. The prescriber will be asked to prescribe a generic or alternate brand medication before other drugs are covered. In the event that the prescriber advises CVS Caremark that a generic or alternate brand medication is not right for you, the prescriber can then call the CVS Caremark Prior Authorization Department to seek approval for the other medication.

Quantity Limits

The Quantity Limit Program is designed to make the use of prescription drugs safer and more affordable. If a medication you take is subject to the Quantity Limit Program, your prescription will be filled only for the quantity considered safe and clinically appropriate.

These quantity restrictions are based on manufacturer or clinically approved guidelines and are subject to periodic review and change. If you require more than the initial quantity limit for a medication subject to the Quantity Limit Program, your **doctor**/prescriber can provide medical necessity information for review by CVS Caremark that explains why more of the medication is clinically necessary. The request will be reviewed by CVS Caremark and you and your prescriber will be notified of the decision.

Frequency Limitation

All prescriptions for proton pump inhibitors ("PPIs"), such as Nexium or Omeprazole, will be filled for no more than a 90-day supply in a 180-day period.

Claims for Non-Participating Pharmacies

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

Contact CVS Caremark at 1-877-765-6294 before having the prescription filled to ensure that you will receive reimbursement for the prescription. If you have a prescription filled for a drug that is on the list of those requiring prior authorization or is subject to quantity limits or step therapy and you fail to contact CVS Caremark before having the prescription filled, you may be responsible for the full cost of the prescription drug.

Eligible Drugs

The following are covered under the Plan:

- Federal legend prescription drugs,
- drugs requiring a prescription under applicable state law,
- insulin, insulin syringes and needles,

- diabetic test strips,
- all FDA approved types of contraceptives, including oral and sub-dermal contraceptive prescriptions, contraceptive injections and miscellaneous contraceptive devices, with no **copay** required,
- prescription vitamins for infants up to 12 months of age, and
- prenatal vitamins, with no **copay** required, for up to 15 months.

Excluded Drugs

The following are not covered under the Plan:

- over-the-counter drugs and vitamins (however, certain vitamins are covered for prenatal care—see above for information),
- prescription drugs that require prior authorization and for which you have not received prior authorization,
- drugs used in clinical trials or experimental studies,
- drugs used for infertility treatment or egg donation,
- drugs prescribed for cosmetic purposes (see footnote 16 on page 133 for more information),
- drugs used for weight loss unless you meet the Plan’s medical criteria,
- non-formulary drugs, unless you can prove **medical necessity** via clinical documentation or the patient’s drug therapy history to CVS Caremark’s satisfaction that the non-formulary drug is necessary (non-formulary drugs are drugs that are not on the Plan’s list of approved drugs and medicines),
- therapeutic devices or appliances, support garments and other non-medical substances, and
- prescriptions that an eligible person is entitled to receive without charge under any Workers’ Compensation law, or any municipal, state or Federal program.

Dental Benefits

For all Metropolitan Plan participants and Suburban Plan participants who work in the New York Metropolitan area, your dental benefits are described on pages 57–68. *Dental benefits for Suburban Plan members who work and live outside the New York Metropolitan area, including Connecticut, Pennsylvania, Maryland, Virginia, Washington, DC, Florida, or New England are described in Appendix A on pages 134–141.*

How the Plan Works

The Plan provides coverage for necessary dental care received through:

- a **Delta Dental participating dentist**,
- a non-participating dentist, or
- the 32BJ Dental Center at 25 West 18th Street, New York, NY 10011-4676.

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

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

The Plan reserves the right to withhold payment or request reimbursement from providers or participants for services that do not meet acceptable standards, as determined by the Plan’s consultants or professional staff.

Participating Dental Providers

The Plan's dental benefits include a "participating dental provider" feature through Delta Dental. The Delta Dental **network** that covers you depends on where you live. If you live in New York State, you and your eligible dependent(s) are covered by the Delta Dental NY Select **network**. If you live outside New York State, you and your eligible dependent(s) are covered by the Delta Dental PPO **network**.

Whether a dentist is a participating dentist depends on the **network** that covers you. For example, if you are covered by the NY Select **network**, any dental services provided by a dentist not in the NY Select **network** will be covered **out-of-network**. So, a dentist who participates in Delta Dental's **networks**, but not the NY Select **network** is not a participating dentist. If you use that dentist, your claims will be processed **out-of-network**. The Fund will pay the lesser of the dentist's actual charge for a covered dental service or 50% of the **allowed amount** for that procedure according to Delta Dental's NY Select fee schedule. You will be responsible for the other 50%, plus any additional amount charged above the **allowed amount**. The dentist will be reimbursed according to Delta Dental's NY Select fee schedule's **allowed amount** for each procedure. You will be responsible for any amount charged by the dentist above the **allowed amount**. If you have questions on which **network** covers you or to find a dentist, please contact the dedicated 32BJ Delta Dental number at 1-800-589-4627 or visit www.deltadentalins.com/32bj for assistance.

Dentists who participate in the **network** that covers you have agreed to accept the amount that Delta Dental pays as payment in full for covered dental care that you receive except for:

- major services, such as fixed bridgework, crowns and dentures, for which you will have to make a \$75 **copay** per service,
- charges in excess of the annual maximum of \$2,000, and
- orthodontic services* for dependents under age 19 in excess of the \$2,500 lifetime limit.

* There is no lifetime limit on the following **medically necessary** orthodontic services: procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Non-Participating Dentists

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

You will be required to pay the dentist's full charges. You will file a claim with Delta Dental (see page 78 and pages 80-81) and will be reimbursed according to the applicable Delta Dental fee schedule for each procedure.

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

The 32BJ Dental Center

The 32BJ Dental Center is equipped to provide a broad range of dental services, except those that require general anesthesia. If you receive your dental care from the 32BJ Dental Center, you will not have to pay for any of that care. The 32BJ Dental Center has a limited capacity and when it reaches the maximum number of patients it can serve, it will temporarily suspend accepting new patient appointments.

Predeterminations/Pretreatment Estimates

If you and your dentist are unsure of your benefit for a specific course of treatment, or if treatment costs are expected to exceed \$300, Delta Dental recommends that you ask for a pretreatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pretreatment estimate requests are not required, but may be submitted for more complicated and expensive procedures, such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. You will receive an estimate of your out-of-pocket expenses, including **copays**, if any, and what Delta Dental will pay before treatment begins. Predeterminations are free and help you and your dentist make informed decisions about your treatment.

Annual Maximum

The Dental Plan provides coverage of up to \$2,000 per participant/dependent age 19 and older per calendar year. There is no annual maximum for participants and dependent(s) under age 19.

Frequency Limitations

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

Schedule of Covered Dental Services (the “Schedule”)

Covered Dental Services are subject to the frequency limitations that are stated in that Schedule. The Plan does not cover benefits for procedures that are not in the Schedule, but may provide an alternate benefit if approved by Delta Dental of New York, Inc. (“Delta Dental”) on behalf of the Fund. Whether you have to pay for those services and, if so, how much, depends on whether you choose to receive your dental care from a **Delta Dental participating dentist**, a non-participating dentist, or the 32BJ Dental Center.

Preventive Services

Benefit	In-Network	Out-of-Network	Limitations
Dental prophylaxis (cleaning, scaling and polishing)	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Two in a calendar year.
Topical fluoride treatment			Two in any calendar year for patients under age 16.
Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)			Once per tooth in any 24 consecutive months period for patients under age 16.
Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)			Once in a lifetime per tooth for patients under age 16.

Diagnostic Services

Benefit	In-Network	Out-of-Network	Limitations
Oral exam, periodic, limited (problem focused), comprehensive or detailed and extensive (problem-focused)	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Two in a calendar year.
X-rays: • full mouth, complete series, including bitewings or panoramic film			Once in any 36 consecutive months period.
• bitewings, back teeth			Two of any bitewing x-ray procedure in a calendar year.
• periapicals, single tooth			As necessary.
• occlusal film			Two per date-of-service.
• cephalometric film or photographic image obtained intra or extra-orally (orthodontic coverage only)			Once in a lifetime.

Simple Restorative Services

Benefit	In-Network	Out-of-Network	Limitations
• Amalgam (metal) fillings	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth surface in any 24 consecutive months period.
• Resin (composite, tooth-colored) fillings on anterior teeth			

Endodontics

Benefit	In-Network	Out-of-Network	Limitations
• Root canal therapy • Retreatment of root canal* • Apicoectomy/Periradicular services (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment) * • Pulpotomy	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in a lifetime.
• Hemisection* • Apexification/Recalcification* • Pulp Capping			Only for children under age 19.

*These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist.

Periodontics

Benefit	In-Network	Out-of-Network	Limitations
<ul style="list-style-type: none"> Gingivectomy or gingivoplasty Osseous surgery* 	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per quadrant in a 60 consecutive months period.
<ul style="list-style-type: none"> Periodontal scaling and root planing 			Once per quadrant in a 24 consecutive months period.
Periodontal maintenance (procedure is a benefit following active periodontal therapy once a 30 day post-operative period has been completed)			Two of any prophylaxis procedure in a calendar year.

* These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist.

Simple Extractions

Benefit	In-Network	Out-of-Network	Limitations
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in a lifetime.

Oral and Maxillofacial Surgery*

Benefit	In-Network	Out-of-Network	Limitations
<ul style="list-style-type: none"> Extractions Removal of impacted tooth,** residual tooth roots 	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in a lifetime.
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)			Once per quadrant in a lifetime.
Frenulectomy **			Once per arch in a lifetime.

* Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm** and incision and drainage of an intraoral or extraoral abscess.**

These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network specialist.

Major Services

Benefit	In-Network	Out-of-Network	Limitations
Recementation of crown, inlay, onlay	Plan pays 100% after \$75 copay	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in any calendar year..
Prefabricated stainless steel/ resin crown (for children only– deciduous teeth only)*			Once per tooth in any 24 consecutive months period.
Inlays, onlays, and crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture			Once per tooth in any 60 consecutive months period.

*These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist

Removable Prosthodontics

Benefit	In-Network	Out-of-Network	Limitations
Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care	Plan pays 100% after \$75 copay	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	One denture per arch within any 60 consecutive months period.
Denture rebase or reline procedures, including six months of routine post-delivery care			Once per appliance in any 36 consecutive months period.
Interim maxillary and mandibular partial denture			Once per appliance in any 60 consecutive months period.
Tissue conditioning			

Fixed Prosthodontics

Benefit	In-Network	Out-of-Network	Limitations
Fixed partial dentures pontics	Plan pays 100% after \$75 copay	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in any 60 consecutive months period.
Fixed partial denture retainers – inlays/onlays, crowns			

Repairs

Benefit	In-Network	Out-of-Network	Limitations
Crown repair	Plan pays 100% after \$75 copay	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in a 24 consecutive months period.
Additions to partial dentures			
Replace broken teeth on denture			Twice in any consecutive 12 months period.

Emergency Treatment

Benefit	In-Network	Out-of-Network	Limitations
Palliative treatment to alleviate immediate discomfort (minor procedure only)	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per date-of-service.

Orthodontic Services*

Benefit	In-Network	Out-of-Network	Limitations
Orthodontics	Plan pays 100% up to lifetime maximum** of \$2,500	Plan pays lesser of actual charges or 50% of the allowed amount up to lifetime maximum* of \$2,500 and the member pays 50% of the allowed amount and any charges above the allowed amount .	Only for children under age 19. \$2,500 lifetime maximum.** One course of treatment*** in a lifetime.

*Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association.

There is no lifetime limit on the following **medically necessary orthodontic services: procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

***A course of treatment includes braces, monthly visits and retainers.

Miscellaneous

Benefit	In-Network	Out-of-Network	Limitations
Occlusal guard	Plan pays 100%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	One appliance in any 60 consecutive months period.

Alternate Benefit for Dental Coverage

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

What Is Not Covered

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

- any services performed before a patient becomes eligible for benefits or after a patient's eligibility terminates, even if a treatment plan has been approved
- reimbursement for any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services
- orthodontic care for individuals age 19 or older
- charges in excess of the **allowed amounts**, or the annual maximum, or the lifetime maximum for orthodontic care
- treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accidental injury
- services or supplies that the Plan determines are experimental or investigative in nature, except to the extent provided by law
- services or treatments that the Plan determines do not have a reasonably favorable prognosis
- any treatment performed principally for cosmetic reasons including, but not limited to, laminate, veneers and tooth bleaching
- special techniques, including precision dentures, overdenture, characterization or personalization of crowns, dentures, fillings or any other service. This includes, but is not limited to, precision attachments and stress-breakers. Full or partial dentures that require special techniques and time due to special problems, such as loss of supporting bone structure, are also excluded
- any procedures, appliances or restorations that alter the "bite", or the way the teeth meet (also referred to as occlusion and vertical dimension), and/or restore or maintain the bite, except as provided under orthodontic benefits. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure loss from attrition and restoration for misalignment of teeth
- any procedures involving full-mouth reconstruction, or any services related to dental implants, including any surgical implant with a prosthetic device attached to it
- diagnosis and/or treatment of jaw joint problems, including temporomandibular joint disorder ("TMJ") syndrome, craniomandibular disorders or other conditions of the joint linking the jaw bone and skull or the complex of muscles, nerves and other tissue related to that joint

- double or multiple abutments
- treatment to correct harmful habits including, but not limited to, smoking and myofunctional therapy
- habit-breaking appliances, except under the orthodontics benefit
- services for plaque-control programs, oral hygiene instruction and dietary counseling
- services related to the replacement or repair of appliances or devices, including:
 - duplicate dentures
 - the replacement of lost, missing or stolen dentures and appliances less than five years from the date of insertion
 - replacement of existing dentures, bridges or appliances that can be repaired in accordance with dental standards
 - adjustments to a prosthetic device within the first six months of its placement
 - replacement or repair of orthodontic appliances
- drugs or medications used or dispensed in the dentist's office (any prescriptions that are required may be covered by the Plan's prescription medication benefit). (See pages 51–56.)
- charges for novocaine, xylocaine, or any similar local anesthetic when the charge is made separately from a covered dental expense
- additional fees charged by a dentist for hospital treatment
- services for which a participant has contractual rights to recover cost, whether a claim is asserted or not, under Workers' Compensation, or automobile, medical, personal injury protection, homeowners or other no-fault insurance
- treatment of conditions caused by war, or any act of war, whether declared or undeclared, or a condition contracted or an accident occurring while on full-time active duty in the armed forces of any country or combination of countries
- any portion of the charges for which benefits are payable under any other part of the Plan
- if a participant transfers from the care of one dentist to another dentist

during the course of treatment, or if more than one dentist renders services for the same procedure, the Plan will not pay benefits greater than what it would have paid if the service had been rendered by one dentist

- transportation to or from treatment
- expenses incurred for broken appointments
- fees for completing reports or for providing records
- any procedures not listed under the Schedule of Covered Dental Services or the Schedule of Covered Dental Services for the Delta Dental PPO Plan

Coordination of Dental Benefits

- When Delta Dental coverage is primary, Delta pays benefits under this Plan as if there is no other coverage.
- When Delta Dental is secondary, and there are remaining expenses of the type allowable under this Plan, Delta Dental will pay only the amount by which the benefits under this Plan exceed the amount of benefits payable under the other program.

The following rules will be followed to establish the order of determining the liability of this Plan or any other programs:

1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent.
2. The program covering the enrollee as a dependent of an employee whose birthday falls earlier in the calendar year will determine its benefits before the program covering the enrollee as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period.

If the other program does not have the rule described in the above paragraph, but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.

3. The program covering the enrollee having custody of the dependent will determine its benefits first; then, the program of the spouse of the parent with custody of the dependent; and, finally, the program of the parent not having custody of the dependent. However, if the specific terms

of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.

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

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

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

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

Vision Care Benefits

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

lenses, you will be responsible for paying for the contact lens fitting fee and the Plan will cover up to \$120 towards the purchase of contact lenses.

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

Overview of Your Vision Benefits

Benefits	In-Network	Out-of-Network
Eye Exam	Plan pays up to \$30	Plan pays up to the allowed amount of \$30
Lenses	Plan pays 100% if chosen from the Plan’s selected collection with Davis Vision	Plan pays up to the allowed amount of \$60
Frames	Plan pays 100% if chosen from the Plan’s selected collection with Davis Vision	Plan pays up to the allowed amount of \$60
Contact Lenses (instead of frames and lenses)	Plan pays up to \$120 for contact lenses. Fitting fee is not covered.	

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

These maximum benefits are payable within any 24-month period,* starting with the date you first incur a vision care expense (typically an eye exam). For example, if you get an eye exam on September 1, 2020, you have up to September 1, 2022 (assuming you remain eligible for Fund benefits) to receive the benefits cited above for the lenses and frames or contacts. Any unused vision care benefits cannot be carried over and used in a subsequent 24-month period.

You can access your Vision Plan benefits by:

- Showing your Davis Vision card to a Davis Vision participating provider, or
- Visiting a **non-participating provider** and later submitting a Vision Plan claim form to Davis Vision for reimbursement. However, there are no **out-of-network** benefits for participants and dependent(s) under age 19.

To find a **participating provider**, visit www.davisvision.com/32bj or call Member Services at 1-800-999-5431.

* Participants and dependent(s) under age 19 are eligible for an **in-network** eye exam once every 12 months.

Eligible Expenses

The Plan covers the following vision care expenses:

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

Excluded Expenses

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

- ophthalmic treatment or services payable under the provisions of any other benefits of the Plan (ophthalmic treatment may be covered under the hospital/medical benefits described on pages 30–43),
- non-prescription eyeglasses,
- exam fitting fees for contact lenses,
- adornment expenses, and
- **out-of-network** benefits for participants and dependent(s) under age 19.

Long-Term Disability (“LTD”) Benefits* (Metropolitan Plan Only)

This Plan may provide monthly income to you if you become totally disabled while you are in **covered employment**. Totally disabled means you are unable to work in any capacity as a result of bodily injury or disease.

Eligibility

Long-Term Disability (“LTD”) benefits are for Metropolitan Plan participants only. Spouses and dependent(s) are not eligible for this benefit. To be eligible for LTD benefits, you must meet the following requirements:

* Long-Term Disability benefits provided under the Suburban Plan for members working under certain contracts in the New England area are described in Appendix B.

- You become totally disabled while working in **covered employment**. If your disability is expected to last more than 12 months, total disability can be established by submitting a Social Security Disability Notice of Award, which states that your case will be reviewed every three or more years. If your disability is expected to last 12 months or less, you may submit a **Physician** Attestation of Disability Statement. If you cannot satisfy one or more of the requirements to receive a disability benefit award from the Social Security Administration for a reason unrelated to your medical or mental condition, the Fund may require you to be examined by Fund-selected **doctors** in an independent medical exam and to submit to a vocational review to confirm your disability. The Board, or its designee(s), has the sole and absolute discretion to make all determinations of disability.
- As of the date you stopped working due to the disability, you had at least 36 consecutive months of eligibility in the Building Service 32BJ Health Fund's Metropolitan Plan as a result of **covered employment**, and the 36 consecutive months of eligibility were immediately prior to the date you stopped working due to the disability. Approved leaves of absence for up to six months during which health care coverage is continued, e.g., the Family and Medical Leave Act (“FMLA”), leave of absence, short-term disability, Workers' Compensation and Arbitration, during the 36 consecutive month period will count toward eligibility for this purpose.

You are not entitled to LTD benefits if you are eligible to commence a normal form pension (i.e., single life pension if you are single; joint and survivor pension if you are married) of \$250 or more per month from the Building Service 32BJ Pension Fund, the 32BJ/Broadway League Pension Fund, or any other pension fund covering members of Local 32BJ (whether or not you elect to commence such a pension).

LTD Benefit Amount

The LTD benefit payable from the Plan is \$250 per month

When Benefits Begin

LTD benefits begin on the first day of the 7th month after your last day worked due to total disability.

Applying for LTD Benefits

To apply for LTD benefits, you must complete a Disability Eligibility Verification Form and submit either a Social Security Disability Notice of Award or a Physician Attestation of Disability Statement. If your disability is expected to last more than 12 months, to receive LTD benefits beyond the 12th month of disability you must submit a Social Security Disability Notice of Award. If you are not eligible for Social Security Disability for non-clinical reasons, you must submit that denial. To get a copy of the LTD application, contact Member Services as soon as you believe you are disabled.

The Fund reserves the right to re-certify your disability. The Fund may also require you to submit proof of continuing receipt of Social Security Disability. The Board, or its designee(s), has the sole and absolute discretion to make all determinations of disability.

When Benefits End

LTD benefits will stop on the first day of the month after any of the following, whichever happens first:

- you work at any job,
- you are no longer totally disabled,
- you are no longer receiving Social Security Disability benefits,
- you have received benefits covering the 7th through 12th months of your disability and have not obtained a Social Security Disability Notice of Award,
- you become eligible to receive a normal form pension (see page 71 for information) of \$250 or more per month, under the Building Service 32BJ Pension Fund, the 32BJ/Broadway League Pension Fund, or any other pension fund covering members of Local 32BJ,*
- you reach age 65, if your disability began before your 60th birthday; or you receive your 60th monthly LTD payment and your disability began on or after your 60th birthday,
- the Fund receives information that indicates you are ineligible for LTD benefits, or
- you die.

* You may continue to be eligible for up to 30 months of hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision benefits as long as you are still considered totally disabled. (See pages 84–86.)

What Is Not Covered

LTD benefits are not payable for disabilities that result directly or indirectly from:

- the participant's attempted suicide or self-inflicted injuries,
- war (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion, and
- the participant's commission of, or attempt to commit, assault, battery or a felony.

Life Insurance Benefits

Your life insurance coverage is insured and administered by MetLife. The Plan pays the premiums required to keep the insurance policy in force, but the Plan does not directly pay any life insurance benefits.

Accordingly, your rights and the rights of your beneficiaries to life insurance benefits are defined and limited by the insurance policy that is in effect at the time of any covered loss. Coverage exclusions may apply. The terms of the insurance policy may change from time-to-time. If the information in this SPD is different from the terms of the policy, that insurance policy will govern your benefit rights. For a copy of the group certificate or for information on coverage exclusions, contact MetLife at 1-866-492-6983.

Benefit Amount

The level of life insurance coverage depends on the Plan that you are covered under. If you are covered under the Metropolitan Plan, your life insurance coverage is \$40,000. If you are covered under the Suburban Plan, your life insurance coverage is \$25,000. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

For a copy of the plan document, information on how to designate a beneficiary or to file a claim, contact MetLife at 1-866-492-6983 or visit mybenefits.metlife.com.

When Life Insurance Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, except as provided on the following page or if you have Fund-paid

Health Extension due to disability or arbitration. (See pages 12–14.) Life insurance coverage also ends if you cancel your coverage under this Plan due to Medicare eligibility. (See pages 10–11 and pages 98–99.) After your group life insurance under the Plan ends, you may be able to convert it to an individual life insurance policy. Contact MetLife at the number above for more information about converting life insurance.

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. If you are eligible for either Long-Term Disability under the Metropolitan Plan or a Disability Pension under the Building Service 32BJ Pension Fund, your life insurance will continue until your disability ends or you reach age 65, whichever happens first. For as long as this extended coverage lasts, your benefit level will be frozen at the level in effect at the time you became disabled.

The Fund reserves the right to re-certify disability as described on page 72. 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 87–96 for information on appealing a denied claim.)

Accidental Death & Dismemberment (“AD&D”) Benefits

Accidental Death & Dismemberment (“AD&D”) insurance, which is insured and 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

Subject to coverage exclusions, 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 is \$40,000 if you are covered under the Metropolitan Plan and \$25,000 if you are covered under the Suburban Plan. 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 \$20,000 if you are covered under the Metropolitan Plan and \$12,500 if you are covered under the Suburban Plan.

When AD&D Coverage Ends

AD&D insurance coverage ends 30 days after you terminate employment. AD&D also ends if you cancel your coverage under this Plan due to Medicare eligibility. (See pages 10–11 and pages 98–99.) Like your life insurance, your AD&D coverage may continue for up to six months while you have Fund-paid Health Extension due to disability or arbitration. (See pages 12–14.)

Contact MetLife at 1-866-492-6983 for more information about your benefit, coverage exclusions or for a copy of your group certificate.

Death Benefit for Pensioners

If you are a pensioner collecting a pension from Program A, B or C of the Building Service 32BJ Pension Fund, you are entitled to a death benefit of \$1,000. However, if you are eligible to receive life insurance coverage from this Plan, this \$1,000 death benefit is not payable.

Your beneficiary for the death benefit will be the person or persons you name in writing on a beneficiary designation form that is recorded in the Fund's electronic record keeping system. Your beneficiary can be anyone you choose, and you can change your beneficiary at any time by completing and submitting a new form to the Retirement Services Department.

If you do not name a beneficiary, your beneficiary dies before you and you have not named a new beneficiary, or you do not have a beneficiary

recorded in the Fund's electronic recordkeeping system, your pensioner death benefit will be payable in the following order:

- 1) your spouse, if living, or
- 2) your estate.

The Plan does not pay this benefit to anyone 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, benefits will be paid as listed above.

Claims and Appeals Procedures

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

Claims for Benefits

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

- inquiries about the Plan's provisions or eligibility that are unrelated to any specific benefit claim,
- a request for prior approval of a benefit that does not require prior approval by the Plan, and
- presentation of a prescription to be filled at a pharmacy that is part of the CVS Caremark **network** of participating pharmacies.

However, if you believe that your prescription has not been filled by a participating pharmacy in accordance with the terms of the Plan, in whole or in part, you may file a claim using the procedures described on the following pages.

Filing Hospital, Medical, Behavioral Health and Substance Abuse Claims

If you use **network** providers, and provide your Empire BlueCross BlueShield card to the provider at the time of service, you do not have to file claims. The providers will do it for you. If you do not provide your Empire BlueCross BlueShield card to the provider at the time of service, you will be responsible for the total charge of the claim. If you use **out-of-network** providers, here are some steps to take to make sure your hospital, medical, behavioral 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 on page 80 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.
- Attach original bills or receipts.
- If you have other coverage and Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits ("EOB") with your itemized bill. (See Coordination of Benefits on pages 97–100.)
- Keep a copy of your claim form and all attachments for your records.

Filing Pharmacy Claims

If you use participating pharmacies or the mail order pharmacy, you do not have to file claims. The participating pharmacies or mail order pharmacy will do it for you. If you use an **out-of-network** pharmacy, then you must file a claim for benefits. Refer to the table on page 80 for information on where to file your claim for benefits received **out-of-network**. **Pharmacy claims should be filed as soon as possible, but never later than 180 days after the date the prescription was filled. Claims filed more than 180 days after the date of service will be denied.**

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

Filing Dental Claims

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

You have to file a claim when you receive care from dentists or other providers or facilities not in the Plan's participating dental provider **network**. You can obtain a claim form by visiting Delta Dental's web site at www.deltadentalins.com/32bj or calling 1-800-589-4627. Refer to the table on page 80 for information on where to file your claim for benefits received **out-of-network**.

Here is what you need to know when you file a dental claim when you do not use a participating dental provider:

- Only an original fully completed claim form or other documents as required by Delta Dental will be accepted for review.
- All necessary diagnostic information must accompany the claim.
- When you are the patient, your original signature or signature on file is acceptable on all claims for payment. If the patient is a child, an original signature or signature on file of the child's parent or guardian is acceptable.
- **All claims must be received by Delta Dental within 180 days after the date of service. Claims received more than 180 days after the date of service will be denied.**
- Payment for all services received from a non-participating dental provider will be made to you. It is your responsibility to pay the dentist directly for services you receive from a non-participating dentist. The Plan will not accept an assignment of benefits to a non-participating dental provider.

The Plan reserves the right to withhold payment or request reimbursement from providers or participants for services that do not meet acceptable standards, as determined by the Plan's consultants or professional staff.

Filing Vision Claims

If you use participating vision providers, you do not have to file claims. The providers will do it for you. If you do not use a participating vision provider, then you must file a vision claim with Davis Vision for reimbursement of eligible expenses. Refer to the table on page 80 for information on where to file your claim for benefits received **out-of-network**. You can obtain a vision claim form from www.davisvision.com/32bj or call 1-800-603-5633. **Vision claims should be filed as soon as possible, but never later than 180 days after the date of service. Claims filed more than 180 days after the date of service will be denied.**

Filing Long-Term Disability ("LTD") Claims

To file a claim for LTD benefits, you must complete a Disability Eligibility Verification Form and a Physician Attestation Statement. A Social Security Disability Notice of Award may be submitted in lieu of a Physician Attestation Statement. If your disability is expected to last more than 12 months, you must submit a Social Security Disability Notice of Award.

If you cannot satisfy one or more of the requirements to receive a disability benefit award from the Social Security Administration for a reason unrelated to your medical or behavioral health condition, the Fund may require you to be examined by Fund-selected **doctors** in an independent medical exam and to submit to a vocational review to confirm your disability. The Board, or its designee(s), has the sole and absolute discretion to make all determinations of disability.

To apply for benefits, contact Member Services as soon as you believe you are disabled and submit proof of your disability (Social Security Disability Notice of Award) along with the Disability Eligibility Verification Form.

Filing for a Pensioner's Death Benefit

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

Filing Life Insurance and AD&D Claims

To file a claim for life insurance or AD&D, your beneficiary must contact MetLife at 1-866-492-6983 or visit mybenefits.metlife.com.

Where to Send Claim Forms

Benefit	Filing Address
Hospital, Medical, Behavioral Health and Substance Abuse (out-of-network only; no claim forms are necessary for in-network care)	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 Attn: Institutional Claims Department (for hospital claims); or, Attn: Medical Claims Department (for medical/professional/ambulance claims)
Pharmacy (non-participating providers only; no claim forms are necessary for participating providers)	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136
Dental (non-participating providers only; no claim forms are necessary for participating providers)	Delta Dental P.O. Box 2105 Mechanicsburg, PA 17055-2105
Vision (non-participating providers only; no claim forms are necessary for participating providers)	Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110
Long-Term Disability (Metropolitan Plan Only)	Building Service 32BJ Benefit Funds 25 West 18th Street New York, NY 10011-4676 Attn: Department of Eligibility
Death Benefit for Pensioners	Building Service 32BJ Benefit Funds 25 West 18th Street New York, NY 10011-4676 Attn: Retirement Services
Life Insurance Accidental Death & Dismemberment	MetLife 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, behavioral health and substance abuse), Ancillary Health Services Claims (pharmacy, dental and vision), Long-Term Disability Claims, Pensioner's Death Benefit Claims and Life/AD&D Claims. These processes are described separately on the following pages. Please review this information to ensure that you are fully aware of these processes and what you, or your authorized representative, need to do in order to comply.

Designating an Authorized Representative

In order to designate someone as your authorized representative to file a claim or an appeal on your behalf, you must submit an authorization, signed by you, which includes:

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

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

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

- *Pre-service claims.* This is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before care is obtained. Prior approval is required for some hospital, medical, behavioral health and substance abuse benefits (see pages 81–84).
- For properly filed pre-service claims, you or your provider will be notified of a decision *within 15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the 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 or your provider improperly file a pre-service claim, you will be notified as soon as possible, but not later than *five days* after receipt of the claim, of the proper procedures to be followed in refileing 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 provider 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 will automatically be treated as such.

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

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

- 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.

* A health care professional with knowledge of your medical condition, or someone to whom you have given authorization may act as an authorized representative. See Designating an Authorized Representative on page 81 for details.

- *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.

Long-Term Disability (“LTD”) Claims (Metropolitan Plan Only)

If you apply for Long-Term Disability, your application will be reviewed by the Fund’s Department of Eligibility to ensure that you meet the eligibility requirements for a Long-Term Disability benefit.

You will be notified *within 45 days* of the date your application is received of whether your application for LTD benefits is approved. If an extension of time is necessary for processing your claim (due to circumstances beyond the control of the Plan, such as an incomplete application), the 45-day period may be extended for an additional 30 days and, if additional time is still needed after the period ends, there may be one more extension of 30 days. If an extension is needed, you will be notified within the initial 45-day period, or the 30 day extension period, as applicable, of the circumstances requiring the extension and the date by which a decision is expected. The notice of extension will inform you of the standards for the Long-Term Disability benefit and the issues delaying the decision on your claim, as well as describe the additional information needed to resolve those issues.

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 Fund receives your response to the request (whichever is earlier). *Within 30 days* after the expiration of this time period, you will be notified of the decision.

If you are found to not meet the requirements for Long-Term Disability, the Fund will provide you with a written denial notice that includes all of the information set forth under the section Notice of Decision on pages 86–87, plus the following if the determination is not based on a finding of disability made by the Social Security Administration:

- (i) a discussion of the decision, including an explanation of the basis for agreeing or disagreeing with: (a) all evidence presented to the Plan of the views of health care professionals treating the claimant and of vocational professionals who evaluated the claimant, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, whether or not the Plan relied on those views, and (c) any determination made by the Social Security Administration regarding the claimant’s disability;
- (ii) any medical necessity or experimental treatment or similar exclusion or limit upon which the denial is based, and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to

the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request;

(iii) the internal rule, guideline, protocol, standard, or similar criterion that was relied upon in making the adverse determination, or alternatively, a statement that no such rule, guideline, protocol, standard, or similar criterion exists;

(iv) upon request, the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(v) a statement that the claimant is entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits.

A denial notice for a disability claim will be provided in a culturally and linguistically appropriate manner, as defined in 29 C.F.R. section 2560.503-1(o).

Pensioner’s Death Benefit Claims

If your beneficiary files a claim for death benefits, the Fund will make a decision on the claim and notify your beneficiary *within 90 days* of receipt of the claim. If the Fund requires an extension of time due to matters beyond its control, the Fund is permitted an additional *90 days*. The Fund will notify your beneficiary prior to 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 the Fund.

Life and AD&D Claims

If you, or your beneficiary, file a claim for either Life or AD&D benefits, MetLife will make a decision on the claim and notify you directly.

Notice of Decision

You will be provided with written notice of a denial of a claim. The denial notice will contain:

- the reason(s) for denial, whether denied, in whole or in part, or if any adverse benefit determination is made (for example, the Plan pays less than 100% of the claim),
- the specific reference to the Plan provision(s) on which the denial is based,

- a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary, and
- a description of the appeals process and time limits, as well as a statement of your right to bring a civil action under the Employee Retirement Income Security Act of 1974 (“ERISA”) Section 502(a) no more than three years after the date an appeal was denied.

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 90–95.

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, behavioral health and substance abuse), Ancillary Health Services Claims (pharmacy, dental and vision), Long-Term Disability Claims (Metropolitan Plan only) and Pensioner’s Death Benefit Claims. For information on appealing a denied Life/AD&D Claims, contact MetLife.

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

Type of Denied Claim	Level-one Appeal	Level-two Appeal
Health Services Claims (Medical Judgment)	Empire BlueCross BlueShield	Independent Review Organization (“IRO”)
Health Services Claims (Administrative)**	Empire BlueCross BlueShield	Board of Trustees*
Ancillary Health Services Claims:		
• Pharmacy (Medical Judgment)	CVS Caremark	Independent Review Organization (“IRO”)
• Pharmacy (Administrative)	CVS Caremark	Board of Trustees*
• Dental	Delta Dental	Board of Trustees*
• Vision	Davis Vision	Board of Trustees*
Life/AD&D	MetLife Insurance Company	Not applicable
LTD (Metropolitan Plan only)	Board of Trustees	Not applicable
Pensioner’s Death Benefit	Board of Trustees	Not applicable

* This level of appeal is voluntary.

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

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.

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 upon request, access to, or copies of, all documents, records or other information relevant to your appeal (including the additional information described on pages 84–86, in the case of an appeal for Long-Term Disability involving a disability determination that was not based on a finding of disability made by the Social Security Administration).

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 file an appeal requesting a review of a denied claim within 180 days of the date of the denial letter, you will waive your appeal right.

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 Behavioral Health Substance Abuse	Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407	1-866-316-3394
Pharmacy	Prescription Claims Appeals CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172	Appeals, except for urgent clinical claims, are only accepted in writing*
Vision	Davis Vision P.O. Box 791 Latham, NY 12110	Appeals are only accepted in writing
Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 Attn: Professional Services	Appeals, except for urgent care, are only accepted in writing**
Long-Term Disability (Metropolitan Plan only)	Board of Trustees' Appeals Committee*** c/o Building Service 32BJ Health Fund 25 West 18th Street New York, NY 10011-4676	Appeals are only accepted in writing
Death Benefit for Pensioners	Board of Trustees' Appeals Committee*** c/o Building Service 32BJ Pension Fund 25 West 18th Street New York, NY 10011-4676	Appeals are only accepted in writing
Life Insurance Accidental Death & Dismemberment	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 1-570-558-8645	Appeals are only accepted in writing

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

** An appeal of an urgent care dental claim also may be filed by calling Delta Dental at 1-800-589-4627.

*** You may appear in person at the Appeals Committee meeting, but you are not required to be there. If you do not attend, the Appeals Committee will decide your appeal based on all of the materials you have submitted.

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, behavioral health and substance abuse) or certain Ancillary Health Services (pharmacy or dental), 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 by calling the numbers set forth in the table under the section Where to File a Level-One Appeal on page 89. You can discuss the reviewer's determination and exchange any necessary information over the phone, via fax or any other quick way of sharing. You will receive a response *within 72 hours* of your request.

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

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

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

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

Request for Expedited Appeal

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

Second Level of Appeal for Claims Involving Medical Judgment

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

Health Services Claims. If you are not fully satisfied with Empire'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 Empire, 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 a Medical Judgment or clinical appropriateness determination by Empire. As noted above, Medical Judgment means a determination based on, but not limited to, the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational.¹⁷ Administrative, eligibility, or benefit coverage limits or exclusions are not eligible for review by the IRO.

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

See footnote 17 on page 133.

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

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

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

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

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

Voluntary Level of Appeal

Administrative Health Services and Pharmacy Claims, and Ancillary Health Services Claims (Dental and Vision)

Once you have received notice of the denial of your timely* level-one appeal of an administrative** Health Services or Pharmacy Claim, or level-one appeal of an Ancillary Services Claim (dental or vision), you have exhausted all required internal appeal options. Please note: there are no expedited appeals for post-service claims under the voluntary appeal procedure.

If you disagree with the decision, you are free to file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"). You may not start a lawsuit to obtain benefits until you have completed the mandatory appeals process and a final decision has been reached, or until the appropriate time frame described in 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 87. Voluntary appeals are heard at regularly scheduled meetings of the Appeals Committee.

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 elect to pursue a claim in court rather than through the voluntary level of appeal. The Plan

* 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.

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

will not impose fees or costs on you (or your authorized representative) because you (or your authorized representative) choose to use the voluntary appeals process. Your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan. Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including your right to representation.

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

LTD (Metropolitan Plan Only) and Pensioner Death Benefit Claim Appeal

If you file an appeal of an LTD or pensioner death benefit claim, a decision will be made at the next regularly scheduled meeting of the Appeals Committee following receipt of your appeal. However, if your request is received less than 30 days before the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than *five days* after the decision has been reached.

Appeal Decision Notice

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

written appeal decision notice will include all of the information set forth under the section Notice of Decision on pages 86-87. In addition, if your appeal was for Long-Term Disability and the appeal decision was not based on a finding of disability made by the Social Security Administration, your appeal decision notice will also contain:

- (i) a discussion of the decision, including an explanation of the basis for agreeing or disagreeing with: (a) all evidence presented to the Plan of the views of health care professionals treating the claimant and of vocational professionals who evaluated the claimant, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, whether or not the Plan relied on those views, and (c) any determination made by the Social Security Administration regarding the claimant's disability;
- (ii) any medical necessity or experimental treatment or similar exclusion or limit upon which the denial is based, and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request;
- (iii) the internal rule, guideline, protocol, standard, or similar criterion that was relied upon in making the adverse determination, or alternatively, a statement that no such rule, guideline, protocol, standard, or similar criterion exists;
- (iv) upon request, the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- (v) a statement that the claimant is entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits.

A denial notice for a disability claim will be provided in a culturally and linguistically appropriate manner, as defined in 29 C.F.R. section 2560.503-1(o).

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 at the address on page 122. 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.

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.

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 its 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 other plan has better coverage in any area.

Except for the situations such as Medicare and **TRICARE**, as described on pages 98–99 and for dental benefits, as described on pages 67–68, 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.

* There are separate coordination of benefits rules applicable to dental benefits which can be found on pages 67–68.

- If the patient is a dependent child of parents who are not separated or divorced, then the plan covering the parent whose birthday (month and day, not year of birth) falls earlier in the calendar year is primary and pays first. If both parents have the same birthday, the plan covering either parent the longest is primary. 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 parents of a dependent child are legally divorced or separated (and there is no court decree establishing financial responsibility for the child’s healthcare expenses), the plan covering the parent with custody is primary. If the parent with custody is remarried, his or her plan is primary, the step-parent’s plan is secondary and the noncustodial parent’s plan is tertiary. If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child’s healthcare expenses, that parent’s plan is primary, once the plan knows about the decree.
- 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). There is no duplication of benefits and you will not receive reimbursement for more than the allowable charges for the **covered services**, and you will not be reimbursed for required **copays**.

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. Cancellation of your coverage has no impact on your covered **employer’s** obligation to continue making contributions to the Plan on your behalf. 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. When you cancel coverage under this Plan, all benefit coverage is cancelled, including medical, hospital, behavioral health and substance abuse, prescription drug, dental, vision, Life Insurance and Accidental Death & Dismemberment, and Long-Term Disability.

- If you are not in **covered employment** (for example, you are an early or disability retiree or you are receiving LTD benefits) and your dependent(s) is 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. Your dependent(s) must enroll in both Medicare Part A and Part B coverage. If your dependent(s) do not enroll, because this Plan pays as secondary, you will be financially responsible for what Medicare would have paid if your dependent(s) had enrolled. Those covered family members who are not eligible for Medicare continue to receive primary coverage from this Plan. This Plan pays primary for the first six months of short-term disability and Workers’ Compensation. However, Medicare may require enrollment within three months after you turn 65.

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

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

Workers' Compensation. This Plan does not provide benefits for expenses covered by Workers' Compensation or occupational disease laws. If an **employer** disputes the application of Workers' Compensation law for the illness or injury for which expenses are incurred, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law (for information about subrogation and reimbursement of benefits, see pages 101–104).

Your Disclosures to the Fund: Fraud

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

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

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 **copays** 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 **copays**, or **deductibles**, where applicable to the 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 payment, 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 your, or your dependent's, right of recovery, regardless of whether or not you, or your dependent, have been made whole for the 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 payment, compromise, settlement, judgment and/or verdict, to the extent permitted by law,

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

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

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

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

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

Meridian Resource Company
P.O. Box 659940
San Antonio, TX 78265

Overpayments

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

Continued Group Health Coverage

During a Family and Medical Leave

During a Family and Medical Leave ("FMLA"), you may be able to continue all of your medical coverage and other benefits offered through the Plan. In New York State, you may be eligible for Paid Family Leave. Other states may have similar leave requirements. Check with your **employer** to determine if you are eligible for the FMLA or other statutory leave that requires the **employer** to continue Fund contributions.

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 leave for 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 10–14 and pages 107–112 for information on COBRA.) In addition, your dependent(s) may be eligible for health care under **TRICARE**. This Plan will coordinate coverage with **TRICARE**. (See page 99.)

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 **contributing 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, dental, prescription drug and vision coverage.

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

If you are disabled and receiving (or are approved to receive) benefits under statutory short-term disability (limited to six months), Workers' Compensation, Long-Term Disability (Metropolitan Plan only) or a Disability Pension from the Building Service 32BJ Pension Fund, the Plan provides coverage for up to 30 months from your last day worked 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 from your date of termination. In these two cases, 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 Fund-paid Health Extension coverage.

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

COBRA Continuation of Coverage

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

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

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

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

The two periods combined cannot exceed a total of 36 months from the date of your termination (the first Qualifying Event). A second Qualifying Event may also occur for your dependents 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 108.)

*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, under COBRA 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.

If you are age 65 or older when you incur a Qualifying Event that requires an offer of COBRA coverage to you, and your dependent(s), Medicare will be primary and this Plan will be secondary for you, and any of your dependent(s), 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.

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% (or an additional 50% for the 11-month disability extension). The first payment is due no later than 45 days after the election to receive coverage (and it will cover the period from the date you would lose coverage until the date of payment). Thereafter, payments are due on the first of each month. If payment is not received on the first of the month, coverage will be terminated. However, if your payment is made within 30 days of the due date, coverage will be reinstated retroactive to the due date. Costs may change from year-to-year. Contact Member Services for more information about the cost of your COBRA coverage.

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

What COBRA coverage provides. COBRA generally offers the same health coverage that is made available to similarly situated employees or family members; however, Life/AD&D and Long-Term Disability (Metropolitan Plan only) are not available, except as provided under Fund-paid Health Extension for up to six months. If, during the period of COBRA continuation coverage, the Plan's health 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 108. 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.
- 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. In order to appoint a provider as your authorized representative, you must submit a legibly signed authorization with your appeal that includes all of the information set forth in the section Designating an Authorized Representative on page 81.

Qualified Medical Child Support Order

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 122.

No Liability for Practice of Medicine

The selection of a health care provider is solely your decision. 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. Therefore, neither the Fund, the Board nor any of their designees are responsible for, or will have any liability whatsoever for, the actions or inactions of any health care provider selected under this Plan, including, but not limited to, any negligence or medical malpractice on the part of such health care provider.

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 participants. Anyone may request an additional copy of this Notice by contacting the Compliance Office at the address on page 122.

The Fund’s Board of Trustees adopted certain HIPAA privacy and security policies that require 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 122.

Converting to Individual Coverage

Life Insurance. After your group life insurance under the Plan ends, you may be able to convert it to an individual life insurance policy. Contact MetLife for information.

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

General Information

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between the Realty Advisory Board on Labor Relations, Inc., or other **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, the 32BJ Benefit Funds and the Realty Advisory Board) 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, or
- cash checks within 18 months of the date issued. The amounts of such uncashed checks or other unclaimed funds are not subject to any escheat laws and remain the assets of the Plan. Uncashed checks or other unclaimed funds 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 10–14 and pages 107–112).

If the Plan mistakenly pays more than you are eligible for, or pays benefits that were not authorized by the Plan, the Fund may seek any permissible remedy allowed by law to recover benefits paid in error. (Also, see Subrogation and Reimbursement on pages 101–104 and Overpayments on page 105.)

Compliance with Federal Law

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

Plan Amendment or Termination

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

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

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

Plan Administration

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

The Plan is administered by the Board of Trustees, except those portions provided by insurers in fully insured arrangements. 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, as amended (“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 copies of documents other than this SPD.
- 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 10–14 and pages 107–112 for information about COBRA), and the documents governing the Plan on the rules governing your COBRA continuation rights.

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.

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 76–96. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from

the Plan administrator, you should contact the nearest office of EBSA, U.S. Department of Labor, listed in your telephone directory, or the:

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

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

Plan Facts

This SPD is the formal plan document for the Metropolitan and Suburban Plans 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 and Guardian Life Insurance Company of America insures the STD and LTD benefits provided under the Suburban Plan. All contributions to the Trust Fund are made by **contributing employers** under the Plan in accordance with their written agreements. Benefits, are administered by the organizations listed in the table on page 89.

Plan Sponsor and Administrator

The Plan is administered by a joint Board of Trustees consisting of Union Trustees and **Employer** Trustees. 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 each **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, Customer Relations, 500 Schoolhouse Road, Johnstown, PA 15904 or upon the supervisory official of the Insurance Department of the state in which you reside. For disputes arising under the portion of the Plan insured by Guardian, legal process may be served at the 10 Hudson Yards, Corporate Compliance: Complaints Dept., New York, NY 10001.

Glossary

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

Co-insurance is the percentage of costs of a covered health care service you pay after you have paid your **deductible**.

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**.

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

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

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

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

Delta Dental participating dentist means a dentist that participates in the **network** (NY Select or PPO) that covers you. For example, if you are covered by the NY Select **network**, a dentist that participates only in the PPO **network** is not a **participating dentist**.

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.

Employer (see **Contributing employer**).

Freestanding Facility means an entity that provides health care services and that is neither integrated with, nor a department of, a hospital. Physically separate facilities on the grounds of a hospital are considered freestanding unless they are integrated with, or a department of, the hospital.

In-network (or **participating**) **providers** and suppliers are those who have contracted with the Fund, Empire, CVS Caremark, Delta Dental, Davis Vision or with any other administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services provided must fall within the scope of their individual professional licenses.

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

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

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

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

Non-Preferred in-network hospitals and facilities (Non-Preferred hospitals and facilities) are those that have higher costs for care and have been identified as such by the Plan. **Non-Preferred hospitals and facilities** have higher **copays**.

Out-of-network (non-participating) 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, behavioral health and substance abuse, vision or dental services. **Out-of-network** benefits are benefits for **covered services** provided by **out-of-network** providers and suppliers.

Participating provider (see **in-network provider**).

Preferred in-network hospitals and facilities (Preferred hospitals and facilities) are those that have lower costs for care and have been identified as such by the Plan. **Preferred hospitals and facilities** have lower **copays**.

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

Footnotes

- 1 **Hospital/facility** is a fully licensed acute-care general facility that has all of the following on its own premises:
 - a broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies,
 - 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times,
 - a fully staffed operating room suitable for major surgery, together with anesthesia service and equipment (the hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care),
 - assigned **emergency** personnel and a “crash cart” to treat cardiac arrest and other medical emergencies,
 - diagnostic radiology facilities,
 - a pathology laboratory, and
 - an organized medical staff of licensed **doctors**.

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

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

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

Blue Distinction Centers of Medical Excellence have demonstrated their commitment to quality care, resulting in overall better outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert **physicians'** and medical organizations' recommendations, including the Center for International Blood and Marrow Transplant Research, the Scientific Registry of Transplant Recipients and the Foundation for the Accreditation of Cellular Therapy and is subject to periodic re-evaluation as criteria continue to evolve.

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

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

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

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

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

- at home, when provided, supervised and arranged by a **doctor** and the patient has registered with an approved kidney disease treatment center (not covered: professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment), or
- in a hospital-based or **Freestanding Facility** within the Empire **network**. See details in footnote 1.

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 calendar 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-network** only; there are no **out-of-network** hospice benefits. The Plan covers hospice services when the patient's **doctor** certifies that the patient is terminally ill and the hospice care is provided by a hospice organization certified by the state in which the hospice organization is located. Hospice care services include:

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

6 **Home health care** means services and supplies, including nursing care by a registered nurse ("RN") or licensed practical nurse ("LPN") and home health aid services. The Plan covers up to 200 home health care visits per person per calendar year (**in-network** only), as long as your **doctor** certifies that home health care is **medically necessary** and submits 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 (the Plan will cover a home health aide as long as the services provided are part of skilled nursing health care). 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, and
- laboratory tests.

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**.

8 **Emergency room treatment benefits** Remember to contact the Pre-authorization Service at the phone number on the back of your Empire ID Card within 48 hours of an **emergency** hospital admission, as described on pages 27–33, to pre-authorize any continued stay in the hospital. If you have an **emergency** outside the Empire POS Operating Area (see page 27), show your Empire ID Card when visiting a local BlueCross BlueShield **participating provider**. If the hospital participates with another BlueCross and/or BlueShield program, your claim will be processed by the local BlueCross plan. If it is a non-participating hospital, you will need to file a claim in order to be reimbursed for your eligible expenses.

9 **Ambulance Services** are covered in an **emergency** and in other situations when it is medically appropriate (such as taking a patient home when the patient has a major fracture or needs oxygen during the trip home).

Air ambulance is covered when the patient's medical condition is such that the time needed to transport by land poses a threat to the patient's survival or seriously endangers the patient's health, or the patient's location is such that accessibility is only feasible by air transportation, and the patient is transported to the nearest hospital with appropriate facilities for treatment and there is a medical condition that is life threatening.

Ambulance services are not covered if, after transport, you do not receive treating services.

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 the ambulance transportation would enable the patient to receive a more timely **medically necessary** intervention (such as PTCA or fibrinolytic therapy).

Pre-authorization of air ambulance is required in non-emergency situations.

10 **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 page 38. 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, other immunizations as determined by the American Academy of Pediatrics, Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.

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

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

13 **Physical therapy**, physical medicine and rehabilitation services, along with speech, vision, and occupational therapy, 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. For outpatient physical therapy, your participating therapist will pre-certify services required after your first assessment visit.

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

- prosthetics/orthotics and durable medical equipment from suppliers, when prescribed by a **doctor** and approved by Empire including:
 - artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses,
 - supportive devices essential to the use of an artificial limb,
 - corrective braces,
 - wheelchairs, hospital-type beds, oxygen equipment and sleep apnea monitors,
 - replacement of covered medical equipment because of wear, damage, growth or change in the patient's need when ordered by a **doctor**, and
 - reasonable cost of repairs and maintenance for covered medical equipment.
- The **network** supplier must obtain pre-authorization for the rental or purchase of durable medical equipment. In addition, the Plan may 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.

Routine foot orthotics are not covered.

15 **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**.

16 **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 injury.

17 **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 (the "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.

Appendix A

The following dental benefits are for Suburban members who work and live outside the New York Metropolitan area, including Connecticut, Pennsylvania, Maryland, Virginia, Washington, DC, Florida, or New England.

How the Plan Works

The Plan provides coverage for necessary dental care received through:

- a Delta Dental PPO participating dentist, or
- a non-Delta Dental dentist.

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

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

Participating Dental Providers

The Dental Plan's dental benefits include a "participating dental provider" feature through Delta Dental. The Delta Dental PPO **network** is the Plan's participating dental provider **network**. Dentists who participate in the Delta Dental PPO **network** have agreed to accept the amount that Delta Dental pays as payment in full for diagnostic and preventive services or partial payment for other dental services.

- If you choose to receive your care from a participating PPO dental provider, you will not have to pay anything for covered dental care that is diagnostic or preventive, and
- For all other services, you will pay the difference between the Delta Dental PPO fee schedule maximum allowance (or the dentist's charges if less) and the Dental Plan's reimbursement.

Non-Participating Dentists

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

You will be required to pay the dentist's full charges. You will file a claim with Delta Dental (see page 78 and page 80) and will be reimbursed according to the Delta Dental PPO fee schedule for each procedure.

The Fund will pay the lesser of the dentist's actual charge for a covered dental service or the **allowed amount** for that procedure according to Delta Dental's PPO fee schedule.

Annual Maximum

The Dental Plan provides coverage of up to \$1,000 per participant or dependent age 19 and older per calendar year. There is no annual maximum for participants and dependent(s) under age 19.

Frequency Limitations

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

Schedule of Covered Dental Services

Covered services are listed in the Schedule of Covered Dental Services (the “Schedule”), subject to frequency limitations that are stated in that Schedule. The Plan pays no benefits for procedures that are not in that Schedule, but may provide an alternate benefit if approved by the Fund. Whether you have to pay for those services and, if so, how much, depends on whether you choose to receive your dental care from the 32BJ Dental Center, a Delta Dental PPO participating dentist, or from a non-participating dentist.

Preventive Services

Benefit	In-Network	Out-of-Network	Limitations
Dental prophylaxis (cleaning, scaling and polishing)	Plan pays 100%	Plan pays lesser of actual charges or 100% of the allowed amount .	Two in a calendar year.
Topical fluoride treatment			Two in any calendar year for patients under age 16.
Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)			Once per tooth in any 24 consecutive months period for patients under age 16.
Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)			Once in a lifetime per tooth for patients under age 16.

Diagnostic Services

Benefit	In-Network	Out-of-Network	Limitations
Oral exam, periodic, limited (problem focused), comprehensive or detailed and extensive (problem-focused)	Plan pays 100%	Plan pays lesser of actual charges or 100% of the allowed amount .	Two in a calendar year.
X-rays: • full mouth, complete series, including bitewings or panoramic film			Once in any 36 consecutive months period.
• bitewings, back teeth			Two of any bitewing x-ray procedure in a calendar year.
• periapicals, single tooth			As necessary.
• occlusal film			Two per date-of-service.
• cephalometric film or photographic image obtained intra or extra-orally (orthodontic coverage only)			Once in a lifetime.

Simple Restorative Services

Benefit	In-Network	Out-of-Network	Limitations
• Amalgam (metal) fillings	Plan pays 80%	Plan pays lesser of actual charges or 80% of the allowed amount and the member pays 20% of the allowed amount and any charges above the allowed amount .	Once per tooth surface in any 24 consecutive months period.
• Resin (composite, tooth-colored) fillings on anterior teeth			

Endodontics

Benefit	In-Network	Out-of-Network	Limitations
• Root canal therapy • Retreatment of root canal* • Apicoectomy/Periradicular services (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment)* • Pulpotomy	Plan pays 80%	Plan pays lesser of actual charges or 80% of the allowed amount and the member pays 20% of the allowed amount and any charges above the allowed amount .	Once per tooth in a lifetime.
• Hemisection* • Apexification/Recalcification* • Pulp Capping			Only for children under age 19.

*These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist.

Periodontics

Benefit	In-Network	Out-of-Network	Limitations
<ul style="list-style-type: none"> Gingivectomy or gingivoplasty Osseous surgery* 	Plan pays 80%	Plan pays lesser of actual charges or 80% of the allowed amount and the member pays 20% of the allowed amount and any charges above the allowed amount .	Once per quadrant in a 60 consecutive months period.
<ul style="list-style-type: none"> Periodontal scaling and root planing 			Once per quadrant within a 24 consecutive months period.
Periodontal maintenance (procedure is a benefit following active periodontal therapy once a 30 day post-operative period has been completed)			Two of any prophylaxis procedure in a calendar year.

* These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist.

Simple Extractions

Benefit	In-Network	Out-of-Network	Limitations
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Plan pays 80%	Plan pays lesser of actual charges or 80% of the allowed amount and the member pays 20% of the allowed amount and any charges above the allowed amount .	Once per tooth in a lifetime.

Oral and Maxillofacial Surgery*

Benefit	In-Network	Out-of-Network	Limitations
<ul style="list-style-type: none"> Extractions Removal of impacted tooth,** residual tooth roots 	Plan pays 80%	Plan pays lesser of actual charges or 80% of the allowed amount and the member pays 20% of the allowed amount and any charges above the allowed amount .	Once per tooth in a lifetime.
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)			Once per quadrant in a lifetime.
Frenulectomy **			Once per arch in a lifetime.

* Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm** and incision and drainage of an intraoral or extraoral abscess.**

** These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist.

Major Services

Benefit	In-Network	Out-of-Network	Limitations
Recementation of crown, inlay, onlay	Plan pays 50%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in any calendar year.
Prefabricated stainless steel/resin crown (for children only–deciduous teeth only)*			Once per tooth in any 24 consecutive months period.
Inlays, onlays, and crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture			Once per tooth in any 60 consecutive months period.

*These services are not performed in the Dental Center. Dental Center patients will be referred to a Delta Dental **in-network** specialist.

Removable Prosthodontics

Benefit	In-Network	Out-of-Network	Limitations
Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care	Plan pays 50%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	One denture per arch within any 60 consecutive months period.
Denture rebase or reline procedures, including six months of routine post-delivery care			Once per appliance in any 36 consecutive months period.
Interim maxillary and mandibular partial denture			Once per appliance in any 60 consecutive months period.
Tissue conditioning			

Fixed Prosthodontics

Benefit	In-Network	Out-of-Network	Limitations
Fixed partial dentures pontics	Plan pays 50%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in any 60 consecutive months period.
Fixed partial denture retainers–inlays/onlays, crowns			

Repairs

Benefit	In-Network	Out-of-Network	Limitations
Crown repair	Plan pays 50%	Plan pays lesser of actual charges or 50% of the allowed amount and the member pays 50% of the allowed amount and any charges above the allowed amount .	Once per tooth in any 24 consecutive months period.
Additions to partial dentures			
Replace broken teeth on denture			Twice in any consecutive 12 months.

Emergency Treatment

Benefit	In-Network	Out-of-Network	Limitations
Palliative treatment to alleviate immediate discomfort (minor procedure only)	Plan pays 100%	Plan pays lesser of actual charges or 100% of the allowed amount .	Once per date-of-service.

Orthodontic Services*

Benefit	In-Network	Out-of-Network	Limitations
Orthodontics	Plan pays 100% up to lifetime maximum** of \$1,000	Plan pays lesser of actual charges or 50% of the allowed amount up to lifetime maximum* of \$1,000.	Only for children under age 19. \$1,000 lifetime maximum.** One course of treatment*** in a lifetime.

* Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association.

** There is no lifetime limit on the following **medically necessary** orthodontic services: procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

*** A course of treatment includes braces, monthly visits and retainers.

Miscellaneous

Benefit	In-Network	Out-of-Network	Limitations
Occlusal guard	Plan pays 100%	Plan pays lesser of actual charges or 100% of the allowed amount .	One appliance in any 60 consecutive months period.

Predeterminations/Pretreatment Estimates

See page 59 for the procedure to obtain predeterminations and pretreatment estimates before you have dental services performed.

Alternate Benefit for Dental Coverage

See page 64.

What Is Not Covered

See pages 65–67.

Coordination of Dental Benefits

See pages 67–68.

Claims and Appeals Procedures

See generally pages 76–96. See page 78 for Filing Dental Claims, page 80 for Where to Send Claim Forms, pages 87–96 for Appealing Denied Claims and pages 93–96 for Voluntary Level of Appeal.

Appendix B

The Suburban Plan offers Short-Term Disability (“STD”) and Long-Term Disability (“LTD”) benefits through Guardian Life Insurance Company of America (“Guardian”) to participants working in the New England area under collective bargaining agreements where the signatory **employer** is required to contribute at a rate that covers STD and LTD benefits. The insurance contracts for those benefits are the plan documents. The plans and the benefits they pay are limited by all the terms, exclusions, and limitations of those contracts in force at the time the disability begins. For information regarding benefits and exclusions or limitations, contact Guardian by calling 1-888-262-5670. The Board reserves the right to change insurance carriers and contracts. You may request copies of your policy from Guardian by calling 1-888-262-5670.

Filing a Claim for STD or LTD Benefits

To file a claim for STD or LTD benefits contact Guardian TeleGuard at 1-888-262-5670, Monday through Friday 8:00 am–8:00 pm. If you file a claim for STD or LTD benefits, Guardian will make a decision on the claim and notify you directly.

Appealing a Denied Claim for STD or LTD Benefits

If your claim for STD or LTD benefits is denied, in whole or in part, Guardian will provide you with information on how to appeal.

Contact Information

What do you need?	Who to contact	How
<ul style="list-style-type: none"> • General information about your eligibility and benefits • Information on your hospital, medical, vision, dental and disability benefits and claims 	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Visit the Welcome Center at 25 West 18th Street 8:30 am–6:00 pm Monday–Friday
<ul style="list-style-type: none"> • To find a 5 Star Center • To find a primary care physician • To find participating Empire BlueCross BlueShield providers 	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Visit www.32bjfunds.org
<ul style="list-style-type: none"> • To find a participating dental plan provider 	Delta Dental	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Dental: Visit www.deltadentalins.com/32bj
To make a dental center appointment	Dental Center	Call 1-212-388-2099 Monday–Thursday 7:30 am–7:00 pm Friday, 7:30 am–5:00 pm Saturday, 8:00 am–4:00 pm
To find a participating vision plan provider	Davis Vision	Call 1-800-999-5431 8:00 am–11 pm Monday–Friday Saturday, 9:00 am–4:00 pm Sunday, 12:00 pm–4:00 pm Visit www.davisvision.com/32bj
Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com
To pre-certify a hospital or medical stay	Empire BlueCross BlueShield	Providers call 1-800-982-8089
To pre-certify mental health or substance abuse stay	Empire BlueCross BlueShield	Providers call 1-855-531-6011
<ul style="list-style-type: none"> • To help prevent or report health insurance fraud (hospital or medical) 	Empire Fraud Hotline	Call 1-800-423-7283 9:00 am–5:00 pm Monday–Friday
<ul style="list-style-type: none"> • Information about your prescription drug benefits, formulary listing or participating pharmacy 	CVS Caremark	Call 1-877-765-6294 or Visit www.Caremark.com 24 hours a day/7 days a week
<ul style="list-style-type: none"> • Immediate medical advice 	Nurses Healthline	Call 1-877-825-5276 24 hours a day/7 days a week
<ul style="list-style-type: none"> • Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc. 	Empire BlueCross BlueShield	Call 1-212-388-3660

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Telephone 1-800-551-3225
www.32bjfunds.org