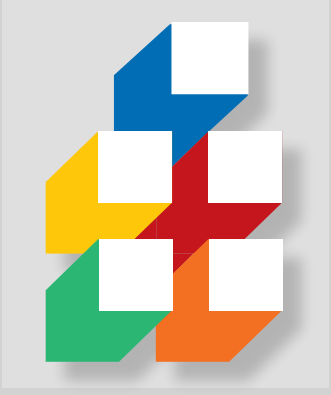
32BJ North Health Fund

Tri-State Preferred North Plan



Summary Plan Description

March 1, 2021

Translation Notice

This booklet contains a summary in English of your rights and benefits under the 32BJ North Health Fund Tri-State Preferred North Plan. 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 North Health Fund Tri-State Preferred North Plan
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 North Health Fund Tri-State Preferred North Plan. 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 North Health Fund Tri-State Preferred North Plan
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 visitor www.32bjfunds.org.

Niniejsza broszura zawiera opis, w języku angielskim, Twoich praw i świadczeń w ramach Planu 32BJ North Health Fund Tri-State Preferred North Plan. 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
332BJ North Health Fund Tri-State Preferred North Plan
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.

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

Member Services
32BJ North Health Fund Tri-State Preferred North Plan
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.

32BJ North

Health Fund

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

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

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Contents

Important Notice

This booklet is both the Plan document and the Summary Plan Description ("SPD") of the plan of benefits (the "Plan") of the 32BJ North Health Fund's (the "Fund") Tri-State Preferred North program 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 described in this SPD and any oral advice you receive from an employee of the Building Service 32BJ Health Fund, 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 Tri-State Preferred North Plan, which includes the hospital, medical, mental health and substance abuse, prescription drug, dental, vision, life insurance and accidental death and dismemberment benefits. The insurance contract from MetLife is the plan document for the Life and Accidental Death & Dismemberment Insurance. The plan and the benefits it pays are limited by all the terms, exclusions and limitations of the contract in force at the time of the covered incident. The Board reserves the right to change insurance carriers and contracts. If the Board makes any such changes, the benefits coverage described in this SPD may not be accurate. You may request copies of the insurance contract from MetLife.

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 March 1, 2021, unless specified otherwise.

Eligibility and Participation

When You Are Eligible

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

Your **employer** will be required to begin making contributions to the Plan on your behalf when you have completed 90 consecutive days of **covered employment** with the same **employer** working full time (as defined by your collective bargaining or participation agreement), unless specified otherwise in the collective bargaining or participation agreement governing your work. For this purpose, **covered employment** includes certain leaves of absence. For example, to the extent required by applicable law, days of illness, pregnancy or injury count toward the 90-day waiting period. Except as otherwise provided on page 10 (see Special Rule for Seasonal Employees), when you have completed that 90-day period working for your **employer**, you and your eligible dependent(s) become eligible for the benefits described in this booklet on your 91st day of **covered employment**.

- This booklet describes the provisions of the Plan in effect as of March 1, 2021.
- In general, the Tri-State Preferred North Plan covers participants who work primarily in the Bronx.

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

- During periods of active work,
- During paid vacation,
- While on jury duty,
- While collecting workers' compensation or short-term disability benefits for the period **employer** contributions are required, up to 26 weeks from the last day worked, and
- During periods of the Family and Medical Leave Act ("FMLA") leave. (See pages 11, and 102 for more information.)

As long as you are eligible for coverage, your dependent(s) are eligible, provided they meet the definition of "dependent" under the Plan (see Dependent Eligibility on pages 11–13) and you have properly enrolled them.

When You Are No Longer Eligible

Your eligibility for benefits under 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**, subject to COBRA rights. (See pages 10–11, and 102–108). To the maximum extent permitted by law, this includes transfer to a job classification outside the jurisdiction of the collective bargaining agreement, layoff, leave of absence or unpaid vacation,
- The earlier of when you have completed 26 weeks of workers' compensation or short-term disability, for a period during which **employer** contributions were required, or when you have exhausted your benefits under workers' compensation or short-term disability for a period during which **employer** contributions are required,
- On the date when your **employer's** participation in the Plan terminates. If your coverage is terminated because your **employer** is delinquent in its contribution obligation to the Fund or because your participation is governed by a collective bargaining agreement that has been expired for at least nine months, your coverage will terminate on the date determined by the Fund's rules and regulations,

- On the date the Plan is terminated, or
- On the date you cancel your coverage because you are eligible for Medicare. (See pages 94–95.)

If You Come Back to Work

If your employment ends after your eligibility began and you return to **covered employment** with the same **contributing employer**, your participation in the Plan will recommence on the first day your **contributing employer** is required to recommence contributions to the Plan on your behalf under its collective bargaining agreement, unless otherwise required by law. If you terminate **covered employment** and return to work with a different **contributing employer**, you must requalify for coverage by satisfying a new waiting period.

Special Rule for Seasonal Employees

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

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, 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 102–108 for more information about COBRA.)

FMLA and Other State Leave

You may be entitled to take a leave of absence for a specified period of time from your job under the Family and Medical Leave Act ("FMLA"), and you may be able to continue health coverage during an FMLA leave. (See page 102 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 102 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.

Dependency	Age Limitation	Requirements
Spouse	None	The person to whom you are legally married. (If you are legally separated* or divorced, your spouse is not covered.)
Children	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child is one of the following: • Your biological child, • Your adopted** child or one placed with you in anticipation of adoption, or • Your stepchild: This includes your spouse's biological or adopted child.
Children (dependent) – Your grandchild, niece or nephew ONLY if you are the legal guardian.**** (If application for legal guardianship is pending, you must provide documentation that papers are filed and provide proof when 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: • Is not married, • Has the same principal address as the participant,*** or as required under the terms of a "QMCSO" (see page 109), 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. You are considered legally separated as of the date an order is entered by the court or the effective date of your separation agreement, whichever is earlier.

** 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 pages 14–15.) 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 12, 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 11–13 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 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 the following page, for further details.)

* Generally, a legal separation is any court order or agreement 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 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.

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 12–13.

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 Childrens' 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 and accidental death and dismemberment benefits. Each of these benefits is described in the sections that follow.

Annual Out-Of-Pocket Maximum on In-Network Hospital, Medical, 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 2021, your annual out-of-pocket maximum is $8,550 and your family's annual out-of-pocket maximum is $17,100.* If you have other family members enrolled in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

* 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.

The annual out-of-pocket maximum for **in-network** benefits is divided between medical and prescription drug benefits as described below. There are no out-of-pocket maximums for **out-of-network** benefits.

Your annual out-of-pocket maximum for individual **in-network** medical benefits in 2021 is $6,750, and your family's annual out-of-pocket maximum for **in-network** medical benefits is $13,500. After a family has spent $13,500 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 noncovered services.

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 audiotaped 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 nonurgent 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 26–40.)

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 **co-insurance** to pay, and no claims to file or track. (See the Schedule of Covered Services on pages 26–40 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 i**n-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 50% 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 26-40 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 its agreement in writing.

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

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

*Annual **deductible***. Your individual annual **deductible** is $500 and your family annual **deductible** is $1,000. 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 annual **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 40–47.)

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

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

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

- **In-network 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 40–47.)

If you decide to use an **out-of-network provider**, you may have significant out-of-pocket costs. Although the Plan pays 50% of the **allowed amount**, the **out-of-network provider** may charge you more than the **allowed amount,** and that amount is solely your responsibility.

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**	**$500**
You also pay 50% of the **allowed amount** after your **deductible** (**co-insurance**)	$1,450 - $500 = $950 $950 x 50% = **$475**
You also pay the difference between the **allowed amount** and the provider charge	$17,000 - $1,450 = **$15,550**
Total Amount You Owe	**$500 + $475 + $15,550 = $16,525**
Plan pays 50% of the **allowed amount** after your **deductible**	$1,450 - $500 = $950 $950 x 50% = $475
Total Amount the Plan Pays	**$475**

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 even if the procedure is **medically necessary**, 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 26–40.)

Coverage When You Are Away from Home

When you are outside of the area covered by the POS **network** (see footnote 8 on page 126), you are covered for all **medically necessary** care on an i**n-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 the opposite page, 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
• Air ambulance[9] (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.
• Surgical procedures (inpatient and outpatient)	Two weeks before you receive surgery or as soon as care is scheduled.
Inpatient: • Scheduled hospital, behavioral health or substance abuse admissions • Hospice • Admission to skilled nursing or rehabilitation facility	Two weeks before you receive care or as soon as care is scheduled.
• Maternity admissions • **Emergency** admissions	Within 48 hours after delivery or admission.
• Maternity admissions lasting longer than two days (or four days for cesarean delivery) • Ongoing hospitalization	As soon as you know care is lasting longer than originally planned.

See footnote 9 on page 126.

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 77–81.)

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 Hospital[1] and Other Inpatient Treatment Centers*

Benefit	In-Network Hospital or 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 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all charges above the **allowed amount**.	
In-hospital services of **doctors** and surgeons and other professionals	Plan pays 100%		
In-hospital anesthesia and oxygen			
In-hospital blood and blood transfusions			
Cardiac Care Unit ("CCU") and Intensive Care Unit ("ICU")			
Inpatient chemotherapy and radiation therapy			
Inpatient kidney dialysis[3]			
Medically necessary special diet and nutritional services while in the hospital			
Inpatient lab and radiology services (including hi-tech radiology)			

* 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**.

For definitions of various facilities and further details, see footnote 1 on page 123 and footnote 3 on page 124.

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

Benefit	In-Network Hospital or 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 nondesignated surgeons at MSSLH or at another **Preferred Blue Distinction Center of Medical Excellence** 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 Center of Medical Excellence**, 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 Centers of Medical Excellence 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. 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.
Lifetime travel maximum for a transplant	Up to $10,000 per transplant.		

* Pre-authorization required for all inpatient admissions.

For definitions of various facilities and further details, see footnote 1 on page 123.

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

Benefit	In-Network Hospital or 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 nondesignated 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 50% of the **allowed amount**, and member pays 50% after the **deductible** and all 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 50% of the **allowed amount**, the member pays 50% after the **deductible** and all 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 page 123, footnote 4 on page 124 and footnote 5 on page 125.

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 the first two visits per person during a calendar year; then a $200 **copay** per visit for the rest of the calendar year.	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 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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 footnotes 8 and 9 on page 126.

Outpatient Treatment Facilities

Benefit	In-Network Hospital or Facility	Out-of- Network Hospital or Facility	Limitations
Presurgical testing	Plan pays 100%.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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: If in outpatient hospital setting: $75 **copay** for **Preferred hospitals** and $250 **copay** for **Non-preferred hospitals**. If in an office or **Freestanding Facility**: $0 **copay**.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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)			
Radiation therapy*			
Chemotherapy*			
Hyperbaric Oxygen Treatment*			
Kidney dialysis[3]*		Not covered	**In-network** only.
Hi-tech imaging (CAT, MRI, MRA, PET, and nuclear imaging)*	Plan pays 100% after $100 **copay** at **Preferred hospitals** or independent facilities, or $250 **copay** at **Non-preferred hospitals**.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all charges above the **allowed amount.**	
Blood tests	Plan pays 100%.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all charges above the **allowed amount**.	

* Pre-authorization required.

See footnotes 2 and 3 on page 124.

Care in the **Doctor's Office**

<table>
<tr><th>Benefit</th><th>In-Network</th><th>Out-of-Network</th><th>Limitations</th></tr>
<tr><td>Office visits</td><td rowspan="8">Plan pays 100% for office visits with a 5 Star Center provider.

Plan pays 100% after $40 copay for office visits with other in-network providers.</td><td rowspan="7">Plan pays 50% of the allowed amount, and the member pays 50% after the deductible and all charges above the allowed amount.</td><td></td></tr>
<tr><td>Specialist visits</td><td></td></tr>
<tr><td>Allergy care</td><td>Limited to 12 treatment visits per calendar year, plus up to two testing visits per calendar year for allergy care.</td></tr>
<tr><td>Hearing exams</td><td>When medically necessary.</td></tr>
<tr><td>Chiropractic visits</td><td>Limited to ten visits per calendar year.</td></tr>
<tr><td>Podiatric care, including routine foot care</td><td>Excluding routine orthotics. Medically necessary orthotics (shoe inserts) limited to one pair per adult and two pairs per child (under 19) per calendar year.</td></tr>
<tr><td>Acupuncture visits</td><td>Not covered</td><td>In-network only.
Limited to 20 visits per calendar year</td></tr>
<tr><td>Surgery in a doctor's office[2]</td><td rowspan="2">Plan pays 100%.</td><td rowspan="2">Plan pays 50% of the allowed amount, and the member pays 50% after the deductible and all charges above the allowed amount.</td><td></td></tr>
<tr><td>Diagnostic procedures, lab and X-rays</td><td></td></tr>
</table>

See footnote 2 on page 124.

Home Health Services

<table>
<tr><th>Benefit</th><th>In-Network</th><th>Out-of-Network</th><th>Limitations</th></tr>
<tr><td>Home health care visits[6]</td><td rowspan="3">Plan pays 100%.</td><td rowspan="4">Not covered</td><td>In-network only.
Limited to 200 home care visits per calendar year, including home physical therapy.</td></tr>
<tr><td>Home hospice[5]</td><td>In-network only.</td></tr>
<tr><td>Home infusion therapy[7]</td><td>In-network only.</td></tr>
<tr><td>Home kidney dialysis[3]</td><td>Plan pays 100% after copay based on where service is billed:
If billed through an outpatient hospital setting: $75 copay for Preferred hospitals and $250 copay for Non-Preferred hospitals.
If billed through a Freestanding Facility: $0 copay.</td><td>In-network only.</td></tr>
</table>

See footnote 3 on page 124, footnotes 5 and 6 on page 125, and footnote 7 on page 126.

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 50% of the **allowed amount,** and the member pays 50% after the **deductible** and all 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**.		The following services only have one **copay** per episode, which is up to six months of treatment: intensive outpatient behavioral health and substance abuse services.

* Pre-authorization required.

** If you are admitted as an inpatient 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: 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**.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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. 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-woman care, which may include an annual well-woman exam and screening for cervical cancer, pregnancy related screenings and reproductive health screenings			
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 yr. old 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 50% of the a**llowed amount,** and the member pays 50% after the **deductible** and all charges above the **allowed amount**.	Immunizations based on age and health risk factors.
Nutritional counseling			Unlimited.

See footnote 10 on page 127.

* 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,

(***Footnotes continue on the following page.***)

- 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 50% of the **allowed amount**, and member pays 50% after the **deductible** and all 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**. If in an outpatient **Preferred hospital** setting – $75 **copay**. If in an outpatient **Non-preferred hospital** setting – $250 **copay**.		
Abortion, includes elective and nonelective procedures			
Infertility testing			Infertility testing limited to once per calendar year.
Infertility treatment	Not covered.	Not covered.	No coverage for treatment of infertility.

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 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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**. If you are enrolled in the 32BJ Maternity Program and deliver at a hospital in this Program, you may be reimbursed your $100 **copay**.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all charges above the **allowed amount**.	Call Member Services for information on the 32BJ Maternity Program.
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 100%.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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		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 12 on page 127.

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 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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 50% of the **allowed amount**, and the member pays 50% after the **deductible** and all 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 127.

Durable Medical Equipment and Supplies[14]

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 nonroutine 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 48–49 for applicable **copay**.
Wigs	Plan pays 100%	Plan pays 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** after the **deductible** and all 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 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** after the **deductible** and all charges above the **allowed amount**.	Not covered under the Prescription Drug Benefit.
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 equipment providers, contact Member Services.

See footnote 14 on page 127 and footnote 15 on page 128.

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**: 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 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** after the **deductible** and all charges above the **allowed amount**.	Only within 12 months of injury to sound natural teeth.
Repair to natural teeth after injury			

* Dental care is also covered under the Plan's dental benefit described on pages 55–68 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 treatment,[16]

See footnote 16 on page 128.

- To the maximum extent permitted by law, 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 postoperative X-rays) pertaining to routine foot care,
- Routine hearing exams for adults,
- Formal psychological evaluations and fitness for duty opinions,

See footnote 17 on page 128.

- Long-term hospitalization for residential care,
- Training or educational therapy for reading or learning disabilities,
- Testing, screening or treatment for learning disorders, expressive language disorders, mathematics disorders, phonological disorders and communication disorders,
- Treatment for conditions not listed as mental disorders in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders,*
- Behavioral health treatment rendered by 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,
- Ambulette,
- The following specific preventive care services:
  - screening tests done at your place of work at no cost to you
  - physicals for preemployment, 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 120.)
  - use of the emergency room for follow-up visits
- The following specific maternity care services:
  - days in hospital that are not **medically necessary** (beyond the 48-hour/96-hour stays the Fund is required by law to cover)
  - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The additional cost does not count toward your **deductible** or **co-insurance**.)
  - **out-of-network** birthing center facilities
  - private-duty nursing
  - services of a doula
- The following specific inpatient hospital care expenses:
  - private duty nursing
  - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The additional cost does not count toward your **deductible** or **co-insurance**.)
  - diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
  - any part of a hospital stay that is primarily custodial
  - elective cosmetic surgery[16] or any related hospital expense 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 <u>not</u> 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

See footnote 16 on page 128.

- All excluded **out-of-network** services,
- The following specific equipment:
  - air conditioners or purifiers
  - humidifiers (except when needed with CPAP 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
- 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 69–71 to find out how eyeglasses and contact lenses may be covered under the vision benefit
  - routine vision care (see Vision Care Benefits on pages 69–71 for coverage information.)
- The following services that may be covered elsewhere under the Plan:
  - dental treatment, except surgical removal of impacted teeth or treatment of sound natural teeth injured by accident if treated *within 12 months* of the injury; however, see Dental Benefits on pages 55–68
  - 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 48–54 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 55–68)
- 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 97–100)
  - 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 97–100)
- 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 OptumRx®. 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** is required for most contraceptive prescriptions and certain preventive over-the-counter medications prescribed for you. (See Eligible Drugs on page 53.) 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 OptumRx at 1-844-569-4148 or visit www.optumrx.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 CVS Saver Plus Program at any CVS pharmacy, or
2. Through OptumRx Home Delivery.

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* 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.

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.

To use OptumRx Home Delivery, call the OptumRx Member Service Center at1-844-569-4148 or go to the website (www.optumrx.com).

For Specialty Medications*

Your pharmacy benefits cover only specialty medications that are on the OptumRx formulary. Specialty medication should be filled through the Optum® Specialty Pharmacy. There is no coverage for specialty medications that are not on the OptumRx formulary. For information on how to fill a specialty medication call 1-877-838-2907.

Variable **Copay** Program

Many specialty manufacturers offer **copay** coupons to help offset the costs of some specialty drugs. The Variable Copay Program may reduce your **copay** to $0 at Optum® Specialty Pharmacy. You must enroll in the program to receive any available **copay** discount. For information on how to enroll in the Variable Copay Program call 1-877-838-2907.

Prescription Plan Coverage Management Programs

The prescription plan uses programs so that you receive the prescription drugs you need in the appropriate quantity and at a reasonable cost. Coverage management programs include Prior Authorization, Step Therapy and Quantity Limits. Each of these programs is described in detail below and on pages 51–52.

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.

* 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.

The Prior Authorization Program is administered by OptumRx to determine whether your use of certain medications meets the Plan's conditions for coverage and OptumRx's clinical guidelines for use of the specific drug. The prescriber will need to contact the OptumRx 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 is designed to confirm that 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, OptumRx 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 OptumRx that a generic or alternate brand medication is not right for you, the prescriber can then call the OptumRx 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.

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 OptumRx that explains why more of the medication is clinically necessary. The request will be reviewed by OptumRx and you and your prescriber will be notified of the decision.

Specialty Split Fill for Certain Oral Oncology Medications

Often **physicians** change or discontinue certain oral oncology medications. If you are taking one of those medications, Optum® Specialty Pharmacy will only dispense half the prescription until it is determined that you will remain on that medication. If this rule applies to you, you will only be charged half your applicable **copay** for half the prescription. Once the medication is stable, you will be switched to monthly prescriptions and you will be charged the full applicable **copay**.

Medical Necessity Review

Your **doctor** may prescribe you a medication that is not covered on the formulary. You or your **doctor** may request a medical necessity review through OptumRx to seek approval for the medication.

If the medication is approved, and there is a generic equivalent on the formulary, you will have to pay the brand **copay** ($30 or $60) and the difference in cost between the brand and the generic drug. If the medication is approved, and there is no alternative on the formulary, you will have to pay the applicable **copay.**

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 OptumRx to be reimbursed up to the amount OptumRx would have paid a participating pharmacy (minus your **copay**). Contact OptumRx 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 OptumRx.)

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 OptumRx 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, if it is a generic or there is no generic available. Brand contraceptives with generics available will be subject to the brand **copay**,
- Prescription vitamins for infants up to 12 months of age, and
- Prenatal vitamins, with no **copay** required.

Excluded Drugs

The following are not covered under the Plan:

- Over-the-counter drugs and vitamins (however, certain vitamins are covered for prenatal care—see above for information),
- Prescription drugs that require prior authorization and for which you have not received prior authorization,
- Drugs used in clinical trials or experimental studies, except to the extent required by applicable law,

- Drugs used for infertility treatment or egg donation,
- Drugs prescribed for cosmetic purposes (see footnote 16 on page 128 for more information),
- Drugs used for weight loss unless you meet the Plan's medical criteria,
- Nonformulary drugs, unless you can prove medical necessity via clinical documentation or the patient's drug therapy history to OptumRx's satisfaction that the nonformulary drug is necessary (nonformulary drugs are drugs that are not on the Plan's list of approved drugs and medicines),
- Therapeutic devices or appliances, support garments and other nonmedical substances, and
- Prescriptions that an eligible person is entitled to receive without charge under any workers' compensation law, or any municipal, state or federal program.

Dental Benefits

How the Plan Works

The Plan provides coverage for necessary dental care received through:

- A **Delta Dental participating dentist**, or
- A **non-participating** dentist.

Necessary dental care is a service or supply that is required to identify or treat a dental condition, disease or injury. The fact that a dentist prescribes or approves a service or supply, or a court orders 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 75) 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.

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 below and 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**, or 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 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and all 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 nonrestored molar and premolar 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 all 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)		Not Covered.	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 all 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 all charges above the **allowed amount**.	Once per tooth in a lifetime.
• Hemisection • Apexification/ Recalcification • Pulp capping			Only for children under age 19.

Periodontics

Benefit	In-Network	Out-of-Network	Limitations
• 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 all charges above the **allowed amount**.	Once per quadrant in a 60 consecutive months period.
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 postoperative period has been completed)			Two of any prophylaxis procedures in a calendar year.

Simple Extractions

Benefit	In-Network	Out-of-Network	Limitations
Nonsurgical 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 all charges above the **allowed amount**.	Once per tooth in a lifetime.

Oral and Maxillofacial Surgery*

Benefit	In-Network	Out-of-Network	Limitations
• 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 all 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.

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 all 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.

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 all 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 all 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 all 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 all 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.	Not covered.	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 all 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,
- **Out-of-networ**k orthodontia services,
- Charges in excess of the **allowed amount**, 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 48–54.)
- 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 this Plan's coverage is primary, Delta pays benefits under this Plan as if there is no other coverage.
- When this Plan's coverage 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 the Plan's benefits first. If such determination indicates that the Plan 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 amount**. 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).

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

For example, if you get an eye exam on September 1, 2021, you have up to September 1, 2023 (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.

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 (opthalmic treatment may be covered under the hospital/medical benefits described on pages 26–40),
- Nonprescription eyeglasses,
- Exam Fitting fees for contact lenses,
- Adornment expenses, and
- **Out-of-network** benefits for participants and dependent(s) under age 19.

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

Your life insurance coverage is $15,000. 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. Life insurance coverage also ends if you cancel your coverage under this Plan due to Medicare eligibility. (See pages 94–95.) 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. For as long as this extended coverage lasts, your benefit level will be frozen at the level in effect at the time you became disabled.

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

Notice of approval or denial of benefits will be sent to your designated beneficiary in writing. (See pages 82–92 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 $15,000. If you lose one hand at or above the wrist, or one foot at or above the ankle, or sight in one eye, the AD&D benefit payable is $7,500.

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 94–95.)

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

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 OptumRx **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 76 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 as untimely**.
- 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 93–96.)
- 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 76 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 as untimely**.

If you have other coverage and OptumRx 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 93–96.)

Filing Dental Claims

When you see a **participating provider in the Delta Dental network**, this provider will file all claims for you directly with **Delta Dental**, the claims 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 76 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 as untimely.**
- 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 below 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 as untimely.**

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**)	OptumRx Claims Department P.O. Box 650334 Dallas, TX 75265-0334
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
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), and Life/AD&D Claims. These processes are described separately on the following pages. Please review this information so 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, OptumRx, 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 24–40).
- 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 refiling the claim. You will only receive notice of an improperly filed pre-service claim if the claim includes:

- Your name,
- Your current address,
- Your specific medical condition or symptom, and
- A specific treatment, service or product for which approval is requested.

Unless the claim is refiled properly, it will not constitute a claim. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your 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 determined based on the information available.

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

* 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 77 for details.

procedures to follow. This notification may be oral, unless you request written notification. You will only receive notification of a procedural failure if your claim includes:

  - Your name,
  - Your specific medical condition or symptom, and
  - A specific service, treatment or product for which approval is requested.

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

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

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

Ordinarily, you will receive a decision on your post-service claim *within 30 days* from receipt of the claim. This period may be extended one time for up to *15 days* if the extension is necessary due to extraordinary matters. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a determination will be made.

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

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

Life and AD&D Claims

If you, or your beneficiary, file a claim for either Life or AD&D benefits, MetLife will make a decision on the claim and notify you 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 77–81.

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), and Ancillary Health Services Claims (pharmacy, dental and vision). For information on appealing a denied Life/AD&D Claim, 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)	OptumRx	Independent Review Organization ("IRO")
• Pharmacy (Administrative)	OptumRx	Board of Trustees*
• Dental	Delta Dental	Board of Trustees*
• Vision	Davis Vision	Board of Trustees*
Life/AD&D	MetLife Insurance Company	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.

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 claim reviewer's administrative processes for 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 a level-one 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 OptumRx P.O. Box 25184 Santa Ana, CA 92799 Fax: 1-877-239-4565	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.**
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 OptumRx Customer Care at 1-844-569-4148.

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

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 the previous page. 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 nonauthorization of an admission or a continuing inpatient hospital stay. Empire's **physician** reviewer or OptumRx'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 OptumRx will respond orally with a decision *within 72 hours*, and Empire or OptumRx will also send a written notice of the decision.

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

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, or a retroactive rescission of coverage, you may request that your appeal be sent to an Independent Review Organization ("IRO") for review. The IRO is composed of persons who are not employed by Empire, or any of its affiliates. 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 and it is completely voluntary. 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.

See footnote 17 on page 128.

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

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

Pharmacy Claims. If you are not fully satisfied with the decision of OptumRx's level-one appeal review of a claim that involved Medical Judgment, you may request that OptumRx send your appeal to an IRO for review. The IRO is composed of persons who are not employed by OptumRx, 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, and it is purely voluntary. OptumRx 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 OptumRx. 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 OptumRx *within four months* of the date of OptumRx's level-one appeal review denial letter. OptumRx 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 OptumRx's independent medical specialist, the IRO review shall be completed *within 72 hours*.

External Review Process

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

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

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

You are permitted to submit in writing to the assigned IRO, within 10 business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to Empire or OptumRx, as applicable. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if Empire or OptumRx, as applicable, decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

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

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

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

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

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

Voluntary Level of Appeal

Administrative Health Services and Pharmacy Claims, 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 level-one 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 filed more than three years after the date on which the applicable appeal was denied.** Also, all claims for benefits against the Fund must be brought in the federal courts located in New York. Alternately, you may file a voluntary appeal with the Board of Trustees. This voluntary appeal must be filed *within 180 days* of the date of the appeal denial letter provided to you by the applicable reviewer as listed in the table under the section Appealing Denied Claims on page 82. Voluntary appeals are heard at regularly scheduled meetings of the Board of Trustees.

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 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 Board of Trustees at the following address:

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

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

Appeal Decision Notice

You will be notified of the decision of your appeal in writing within five days from the date your appeal is decided by the Board of Trustees. The written appeal decision notice will include all of the information set forth under the section Notice of Decision on pages 81.

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.

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

** 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.

You may not start a lawsuit to obtain benefits until you have completed the mandatory level-one 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**. Also, all claims for benefits against the Fund must be brought in the federal courts located in New York. If there is no decision on the appeal, no lawsuit may be started more than three years after the time when the Board of Trustees should have decided the appeal.

If you have any questions about the appeals process, please contact the Compliance Office at the address on page 117. 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, legal or physical, any payment due may be made instead to someone else, such as a spouse or a legal custodian. The Fund will decide who is entitled to benefits in cases like this.

Mailing Address

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

Coordination of Benefits*

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

The Plan uses the Nonduplication 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 94–96 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 divorced or legally separated (and there is no court decree establishing financial responsibility for the child's health care expenses), the plan covering the parent with custody is primary. If 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 health care 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, and life insurance and Accidental Death & Dismemberment.
- If you are not in **covered employment** (for example, you have extended health coverage while receiving disability 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.

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 97–100).

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 and/or equitable lien by agreement 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 and/or equitable lien by agreement 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 and/or equitable lien by agreement arises through operation of the Plan. No additional subrogation or reimbursement agreement is necessary. The Fund's lien and/or equitable lien by agreement 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 expenses paid on your behalf or on your dependent's behalf. The Fund's lien and/or equitable lien by agreement 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. In addition, the Fund does not reduce its lien for any fees paid to your attorney.

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

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid benefits received by you or your dependents or a representative of you or your dependents (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your dependents for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependents consent and agree that a constructive trust, lien and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment of benefits, and in accordance with that constructive trust, lien and/or equitable lien by agreement, you, and your dependents agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your dependents to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Plan and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependents affirmatively waive any defenses you may

have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to, a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

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 maintain your health coverage.

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 elect to continue your coverage under USERRA.

This continuation coverage operates in the same way as COBRA. (See pages 10–11 and pages 103–108 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 95.)

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, elect to continue your coverage under COBRA and make the required monthly payments. The Fund reserves the right to end your COBRA coverage retroactively if you are determined to be ineligible.

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 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 on page 104.)

*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; except Life/AD&D. 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 104. 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 claim 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 77.

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 117.

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 117.

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 117.

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, or AD&D benefits to individual coverage.

General Information

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between the Bronx 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** may participate in the Fund on behalf of noncollectively bargained employees, if approved by the Trustees, 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 10–11 and pages 103–108).

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 97–100 and Overpayments on page 101–102.)

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), shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan,
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan,
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan,
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, as described in this SPD, the Trust Agreement or other Plan documents,
- Process and approve or deny benefit claims and rule on any benefit exclusions, and
- Determine the standard of proof required in any case.

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

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

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

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

As a participant in the 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 10–1 and pages 103–108 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

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 82–92. 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 Tri-State Preferred North Plan of the Health Fund.

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

Funding of Benefits and Type of Administration

Self-funded, except MetLife insures the Life and AD&D insurance benefits. 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 76.

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

Participating Employers

The Compliance Office will provide you, upon written request, with information as to whether a particular **employer** is contributing to the Plan on behalf of employees working under a written agreement, as well as the address of 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
32BJ North Benefit Funds
25 West 18th Street
New York, NY 10011-4676

To contact the Health Fund, call:

1-800-551-3225

or write to:

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

Agent for Service of Legal Process

The Board has been designated as the agent for the service of legal process. Legal process may be served at the Compliance Office or on the individual Trustees. For disputes arising under the portion of the Plan insured by MetLife, service of legal process may be made upon MetLife, Customer Relations, 500 Schoolhouse Road, Johnstown, PA 15904 or upon the supervisory official of the Insurance Department of the state in which you reside.

Glossary

Allowed amount means the maximum the Fund will pay for a covered service. When you go **in-network**, the **allowed amount** is 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 on your behalf.

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, OptumRx, Delta Dental, Davis Vision or with any other claims administrators under contract with the Fund, to provide services and supplies at a prenegotiated 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**.

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

Non-participating Provider means a provider that *has not agreed* to provide services, treatment and supplies at a pre-negotiated rate under the health, dental, prescription drug and vision plans.

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 above and on pages 25, 38 and 45), 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 twelve 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 24–26 to pre-authorize any continued stay in the hospital. If you have an **emergency** outside the Empire POS Operating Area (see page 23, 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 Hyberbaric 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 35. 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 ***Preplanned 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 precertify 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.

Contact Information

What do you need?	Who to contact	How
• General information about your eligibility and benefits • Information on your hospital, medical, vision, dental and disability benefits and claims	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Visit the Welcome Center at 25 West 18th Street 8:30 am–6:00 pm Monday–Friday
• To find a 5 Star Center • To find a primary care **physician** • To find participating Empire BlueCross BlueShield providers	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Visit www.32bjfunds.org
• To find a participating dental plan provider	Delta Dental	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Dental: Visit www.deltadentalins.com/32bj
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
• To help prevent or report health insurance fraud (hospital or medical)	Empire Fraud Hotline	Call 1-800-423-7283 9:00 am–5:00 pm Monday–Friday
• Information about your prescription drug benefits, formulary listing or participating pharmacy	OptumRx	Call 1-844-569-4148 or Visit www.optumrx.com
• Immediate medical advice	Nurses Healthline	Call 1-877-825-5276 24 hours a day/7 days a week
• Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc.	Empire BlueCross BlueShield	Call 1-212-388-3660

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

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

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

32BJ North Health Fund
Summary of Material Modifications

DATE: June 9, 2021

The Board of Trustees of the 32BJ North Health Fund has adopted the following changes to the 32BJ North Heath Fund's Tri-State Preferred Plan's Summary Plan Description (SPD) dated March 1, 2021. This Summary of Material Modifications (SMM) supplements or modifies the information presented in your SPD. **Please keep this document with your copy of the SPD for future reference.**

Appointment of Union Trustee Page 1: Effective May 10, 2021, Shirley Aldebol has been appointed to replace John Santos as Union Trustee and her contact information is added as follows:

Shirley Aldebol
32BJ SEIU
25 West 18th Street
5th Floor
New York, NY 10011-1991

Print Error Correction Page 12: The single asterisk and associated text is deleted in its entirety and replaced with the following:

* Generally, a legal separation is any court order or agreement 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. You are considered legally separated as of the date an order is entered by the court or the effective date of your separation agreement, whichever is earlier.

Coverage of Cornavirus Vaccines: Effective January 1, 2021, the Fund will cover the cost to administer an immunization intended to prevent or mitigate the coronavirus (COVID-19) disease, provided the immunization has received either (i) a recommendation from the U.S. Preventive Services Task Force or (ii) a recommendation from the Advisory Committee on Immunization Practice, which has been approved by the Center for Disease Control ("Coronavirus Vaccine").

Participants may utilize their pharmacy or medical benefits to cover the cost of the vaccine. If the Coronavirus Vaccine is administered by a provider that participates in the Plan's hospital and medical network with Empire BlueCross BlueShield or a pharmacy that participates in the Plan's PBM network with OptumRx, the Plan will cover the vaccine administration fee at 100% of the negotiated rate. If the Coronavirus Vaccine is administered by an out-of-network provider or pharmacy, the Plan will cover the administration cost up to a maximum of the amount that would be reimbursed by Medicare for the administration of the vaccine. Please note, under federal law, you are not required to pay any amounts out-of-pocket for a Coronavirus Vaccine, including any difference between the charges billed by an out-of-network provider and the amount paid by the Fund.