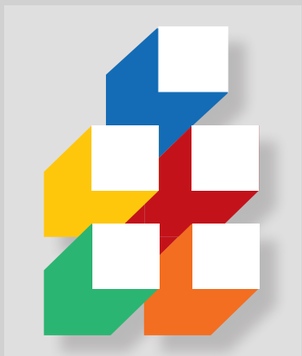
Building Service
32BJ Health Fund

Tri-State Plan



Summary Plan Description

JUNE 1, 2024

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

Translation Notice

This booklet contains a summary in English of your rights and benefits under the Building Service 32BJ Health Fund Tri-State 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
25 West 18th Street
New York, NY 10011-4676
The office hours are from 8:30 a.m. to 8:00 p.m., Monday through Friday and Saturday 9 a.m. to 5 p.m. You may also visit www.32bjfunds.org.

Este folleto contiene un resumen en inglés de sus derechos y beneficios conforme al Building Service 32BJ Health Fund Tri-State Plan. Si tiene alguna dificultad para entender cualquier parte de este folleto, comuníquese con Member Services al 1-800-551-3225 para recibir asistencia, o escriba a la siguiente dirección:

Member Services
25 West 18th Street
New York, NY 10011-4676
El horario de atención es de lunes a viernes de 8:30 a. m. a 8:00 p. m. y los sábados de 9 a. m. a 5 p. m. También puede visitar www.32bjfunds.org.

Bwochi sa a gen yon rezime an anglè sou dwa ak avantaj ou anba Building Service 32BJ Health Fund Tri-State Plan. Si w gen difikilte pou w konprann nenpòt pati nan bwochi sa a, kontakte Sèvis Manm nan 1-800-551-3225 pou asistans oswa ekri nan:

Member Services
25 West 18th Street
New York, NY 10011-4676
Orè biwo a se soti 8:30 am jiska 8:00 pm, Lendi jiska Vandredi ak Samdi 9 am jiska 5 pm Ou ka vizite tou www.32bjfunds.org.

Этот буклет содержит сводную информацию на русском языке о ваших правах и льготах в рамках плана Building Service 32BJ Health Fund Tri-State Plan. Если вы испытываете трудности с пониманием информации, изложенной в какой-либо части этого буклета, обратитесь в отдел обслуживания участников по номеру 1-800-551-3225 за помощью или напишите по следующему адресу:

Member Services
25 West 18th Street
New York, NY 10011-4676
Время работы: с понедельника по пятницу с 8:30 до 20:00 и в субботу с 9:00 до 17:00. Вы также можете посетить веб-сайт www.32bjfunds.org.

Contact Information

WHAT DO YOU NEED?	WHO TO CONTACT	HOW
• General information about your eligibility and benefits • Information on your health, ancillary health and ancillary benefits	Member Services	Call 1-800-551-3225 8:30 am–8:00 pm, Monday–Friday and 9:00 am–5:00 pm, Saturday, or Visit the Welcome Center at 25 West 18th Street, New York NY 8:30 am–6:00 pm, Monday–Friday, or Visit www.32bjfunds.org Log onto the Member Portal at www.32bjmemberportal.org
Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits		
• To find a 5 Star Center • To find a primary care physician • To find an in-network provider	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm, Monday–Friday, or Visit www.32bjfunds.org, or Log onto the Member Portal at www.32bjmemberportal.org
For immediate medical advice	Nurse Helpline Anthem Blue Cross Blue Shield	Call 1-877-825-5276 24 hours a day/7 days a week
To pre-certify: • a hospital or medical stay • a mental health or substance-abuse stay	Anthem Blue Cross Blue Shield	Call 1-800-982-8089 Call 1-855-531-6011
To help prevent or report health insurance fraud (hospital or medical)	Anthem Fraud Hotline	Call 1-800-423-7283 9:00 am–5:00 pm, Monday–Friday
Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc.	Anthem Blue Cross Blue Shield	Providers call 1-800-982-8089
Ancillary Health Benefits		
PRESCRIPTION DRUG BENEFITS • Information about your prescription drug benefits, formulary listing or participating pharmacy	OptumRx	Call 1-844-569-4148 24 hours a day/7 days a week, or Visit www.optumrx.com
DENTAL BENEFITS • Information about your dental benefits or to find a participating dentist	Delta Dental	Call 1-800-589-4627 8:00 am–8pm EST, Monday–Friday, or www.deltadentalins.com/32BJ
VISION BENEFITS • Information about your vision benefits or to find a participating 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
Ancillary Benefits		
• Information about your life insurance plan	MetLife	Call 1-866-492-6983 Visit http://mybenefits.metlife.com

Building Service 32BJ

Health Fund

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

PAGE

IMPORTANT NOTICE 9

SECTION 1: ELIGIBILITY AND PARTICIPATION

A. Eligibility 11
- **1. When You Are Eligible** 11
- **2. When You Are No Longer Eligible** 12
- **3. If You Come Back to Work** 12

B. Extension of Health Benefits 13
- **1. COBRA** 13
- **2. Fund-paid Health Extension** 13
  - Fund-paid Health Extension for Disability 14
  - Fund-paid Health Extension during Arbitration 15
- **3. FMLA and Other State Leave** 15
- **4. Military Leave** 16

C. Dependent Eligibility 16
- **1. Eligible Dependents** 16
- **2. When Your Dependent(s) Are No Longer Eligible** 18

D. Enrollment 19
- **1. How to Enroll** 19
- **2. Special Enrollment Rules** 20
- **3. Your Notification Responsibility** 21

SECTION 2: HEALTH BENEFITS (Medical, Hospital Behavioral Health and Substance Abuse) AND ANCILLARY HEALTH BENEFITS (Prescription Drug, Dental and Vision)

A. Introduction 23
- **1. What Benefits Are Provided** 23
- **2. Annual Out-of-Pocket Maximum on Health (Hospital, Medical, Behavioral Health and Substance Abuse) and Pharmacy Benefits** 24
  - Annual Out-Of-Pocket Maximum on In-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) and Pharmacy Benefits 24
  - Annual Out-of-Pocket Maximum on In-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits 24

Annual Out-Of-Pocket Maximum on In-Network Prescription Drug Benefits. 25
Annual Out-of-Pocket Maximum on Out-of-Network Health (Hospital Medical, Behavioral Health and Substance Abuse) Benefits. 26

B. Health Benefits: Hospital, Medical, Behavioral Health and Substance Abuse Benefits 27

1. How the Health Benefit Works 27
Conditions for Reimbursement 27
I.D. Card. 27
2. In-Network Benefits 28
Types of Out-of-Pocket Costs for In-Network Benefits 28
How to Stay In-Network 29
Annual Out-of-Pocket Maximum 30
Cost Transparency Tool 30
Nurses Healthline. 30
LiveHealth Online 31
3. Out-of-Network Benefits 31
Types of Out-of-Pocket Costs for Out-of-Network Benefits 32
Example of What You Could Pay When You See an Out-of-Network Provider 34
4. Protections Against "Surprise Billing" 35
Emergency services 35
Certain Services at an In-Network Hospital or In-Network Ambulatory Surgical Center. 36
Continuation of Care 37
5. Other Important Information 38
Benefit Maximums. 38
Coverage When You Are Away from Home. 38
Women's Health and Cancer Rights Act (WHCRA) Notice 38
Newborns' and Mothers' Health Protection Act 39
6. Pre-authorization for Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits. 39
7. Schedule of Covered Services 41
In the Hospital and Other Inpatient Treatment Centers. 41
Emergency Care 46

Outpatient Treatment Facilities 47
Care in the Doctor's Office 49
Home Health Services 50
Behavioral Health and Substance Abuse Care 51
Preventive Medical Care 52
Preventive Health Services 53
Reproductive Health Services 54
Pregnancy, Maternity Care and Newborn Care 56
Physical, Occupational, Speech or Vision Therapy (Including Rehabilitation) 58
Durable Medical Equipment, Prosthetics and Non-Durable Medical Equipment and Supplies 59
Dental Care Covered Under Medical Benefit 61
8. Excluded Health (Hospital, Medical, Behavioral Health and Substance Abuse) Expenses 61
C. Prescription Medication Benefit 69
1. How the Prescription Medication Benefit Works 69
2. Types of Out-of-Pocket Costs for Prescription Medication 69
3. 5 Star Wellness Program 71
4. Ways to Get Your Prescriptions Filled 72
Short-term Medications 72
Maintenance Medications 72
Specialty Medications 72
Copay Card Program 73
5. Prescription Plan Coverage Management Programs 73
Prior Authorization 74
Step Therapy 74
Quantity Limits 75
Specialty Split Fill for Certain Oral Oncology Medications 75
Medical Necessity Review 75
6. Eligible Drugs 76
7. Excluded Drugs 76
D. Dental Benefits 77
1. How the Dental Benefit Works 77
Annual Maximum 78
Frequency Limitations 78
2. Participating Dental Providers 78
The 32BJ Dental Center 78
3. Non-Participating Dentists 79

4. **Predeterminations/Pretreatment Estimates** 79
5. **Schedule of Covered Dental Services** 80
Preventive Services 80
Diagnostic Services 80
Simple Restorative Services 81
Endodontics 81
Periodontics 82
Simple Extractions 82
Oral and Maxillofacial Surgery 82
Major Services 83
Removable Prosthodontics 83
Fixed Prosthodontics 83
Repairs 84
Emergency Treatment 84
Miscellaneous Dental 84
Orthodontic Services 85
6. **Alternate Benefit for Dental Coverage** 86
7. **What Is Not Covered** 86
8. **Coordination of Dental Benefits** 89

E. Vision Care Benefits 90
1. **How the Vision Care Benefit Works** 90
2. **Schedule of Covered Vision Services** 91
3. **Eligible Expenses** 92
4. **Excluded Vision Expenses** 92

F. Fertility Benefits Through Progyny 93
1. **How the Fertility Benefit Works** 93
2. **Types of Out-of-Pocket Costs for Fertility Benefits** 94
3. **Exclusions** 95

SECTION 3: ANCILLARY BENEFITS

A. Life Insurance Benefits 96
1. **How Life Insurance Benefits Work** 96
2. **Benefit Amount** 97
3. **When Life Insurance Coverage Ends** 97
4. **Life Insurance Disability Extension** 97

B. Accidental Death & Dismemberment ("AD&D") Benefits 98
1. **How AD&D Benefits Work** 98
2. **When AD&D Coverage Ends** 98

C. Short-Term Disability ("STD") Benefits 99

1. **How Short-Term Disability Benefits Work** 99
2. **Eligibility** 99
3. **When Benefits End** 100
4. **Benefit Limitations and Exclusions** 100
5. **Filing a Claim for STD Benefits** 100
6. **Appealing a Denied Claim for STD Benefits** 101

D. Death Benefit for Pensioners 101

SECTION 4: GETTING YOUR BENEFITS

A. Claims and Appeals Procedures 102
1. **Filing Claims for Benefits** 102
Filing Health (Hospital, Medical, Behavioral Health and Substance Abuse) Claims 102
Filing Pharmacy Claims 103
Filing Dental Claims 103
Filing Vision Claims 104
Filing Fertility Claims 104
Filing for a Pensioner's Death Benefit 105
Filing Life Insurance and AD&D Claims 105
Where to Send Claim Forms 105
Approval and Denial of Claims 106
Designating an Authorized Representative 106
2. **Time Frames for Deciding Claims** 106
Health Services Claims (Hospital, Medical, Behavioral Health and Substance Abuse) Fertility Claims and Ancillary Health Services Claims (Pharmacy, Dental and Vision) 106
Pre-service Claims 107
Urgent Care Request for Benefits 108
Concurrent Claims 109
Post-Service Claims 109
Pensioners Death Benefit Claims 110
Life and AD&D Claims 110
3. **Notice of Decision** 110
4. **Appealing Denied Claims** 111
Filing an Appeal 112
Where to File a Level-One Appeal 113
5. **Time Frames for Decisions on Appeals** 114
Expedited Appeals for Urgent Care Claims 114

Pre-Service or Concurrent Care Health Services (Hospital, Medical, Behavioral Health and Substance Abuse), Ancillary Health Services or Fertility Claim Appeal 115
Post-Service or Concurrent CareHealth Services (Hospital, Medical, Behavioral Health and Substance Abuse), Ancillary Health Services or Fertility Claim Appeal 115
6. External Appeal for Claims Involving Medical Judgment 115
Health Services (Hospital, Medical, Behavioral Health and Substance Abuse) Claims 115
Pharmacy Claims 116
Fertility Claims 117
7. Voluntary Level of Appeal for Administrative Health Claims, Pharmacy Claims, or Fertility Claims, and Level-One Appeal of Dental or Vision Claims 117
Appeal Decision Notice 119
8. Pensioner Death Benefit Claim Appeal 119
9. Further Action 120
B. Incompetence 120
C. No Duplication of Health Coverage 120
D. Mailing Address 121
E. Coordination of Benefits 121
1. Introduction 121
2. Other Health Plans 122
3. Medicare 123
4. TRICARE 124
5. No-fault Benefits 124
6. Other Coverage Provided By State or Federal Law 124
7. Workers' Compensation 125
F. Your Disclosures to the Fund: Fraud 125
G. Subrogation and Reimbursement 126
H. Overpayments 129
I. Continued Group Health Coverage 130
1. During a Family and Medical Leave 130
2. During Military Leave 130
3. Under COBRA 131
COBRA Continuation of Coverage 132

SECTION 5: GENERAL INFORMATION

A. Other Health Plan Information You Should Know 136
1. **Assignment of Plan Benefits** 136
2. **Qualified Medical Child Support Order** 137
3. **No Liability for Practice of Medicine** 137
4. **Privacy of Protected Health Information** 138
5. **Converting to Individual Coverage** 138

B. General Information 138
1. **Employer Contributions** 138
2. **How Benefits May Be Reduced, Delayed or Lost** 139
3. **Compliance with Federal Law** 140
4. **Plan Amendment or Termination** 140
5. **Plan Administration** 140
6. **Statement of Rights under the Employee Retirement Income Security Act of 1974, as Amended** 142
   - Continue Group Health Coverage 142
   - Prudent Action by Plan Fiduciaries 143
   - Enforce Your Rights 143
   - Assistance With Your Questions 144

C. Plan Facts 144
1. **Funding of Benefits and Type of Administration** 145
2. **Plan Sponsor and Administrator** 145
3. **Participating Employers** 145
4. **Agent for Service of Legal Process** 146

D. Glossary 147

SECTION 6: CONTACT INFORMATION ..... Inside Back Cover

Important Notice

We are pleased to provide you with this Summary Plan Description (SPD), which describes in detail the benefits available to covered participants and their eligible dependents under the Building Service 32BJ Health Fund's (the "Fund") Tri-State Plan.

This booklet is both the Plan document and the Summary Plan Description 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" or "Trustees"). You should refer to this booklet when you need information about your Plan benefits. In addition, the Board reserves the right, in its sole and absolute discretion, to amend the Plan at any time.

In the event of conflict or ambiguity between this SPD and your collective bargaining agreement, this SPD will control. Also, in the event there is any conflict between the terms and conditions for the Plan benefits as set forth in this SPD and any information you receive from a Building Service 32BJ Benefit Funds employee, union representative, **claims administrator**, 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.
- Whenever the benefits in this SPD materially change, you will be notified of the modifications.
- If you change your name or address—notify Member Services immediately by calling 1-800-551-3225 so your records are up-to-date.

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* This SPD is the plan document for the Tri-State Plan, which includes hospital, medical, behavioral health and substance abuse, prescription drug, dental, vision, life insurance and accidental death and dismemberment benefits, pensioner death benefits and short-term and long-term disability benefits. Insurance contracts from MetLife and Guardian are the plan documents for the Life and Accidental Death & Dismemberment Insurance and Short-Term and Long-Term Disability Plans. The plans and the benefits they pay are limited by all the terms, exclusions, and limitations of those contracts in force at the time of the covered incident. The Plan pays the premiums required to keep the insurance policies in force, but the Plan does not directly pay any insured benefits. The Board reserves the right to change insurance carriers and contracts. If the Board makes any such changes, the benefits coverage described in this SPD may not be accurate. You may request copies of the insurance contracts from MetLife and Guardian.

- You can also opt into paperless communications by logging into the Fund's online portal at www.32bjmemberportal.org and providing your consent to receive documents electronically via the online Document Center.
- Words that appear in **boldface print** are defined in the Glossary.
- Throughout this booklet, the words "you" and "your" refer to participants whose employment makes them eligible for Plan benefits.
- The Plan is a separate legal entity from 32BJ SEIU. Please remember that all communications (correspondence, forms, payments, documentation, etc.) regarding your health benefits should be sent directly to the Plan and not to 32BJ SEIU. The Plan is not a subsidiary, department, or agent of 32BJ SEIU. No portion of 32BJ SEIU's union dues is used to pay for Plan benefits or operational expenses, except for contributions that 32BJ SEIU makes to the Plan to provide benefits to its own employees.
- 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 June 1, 2024.
- The level of contributions provided for in your collective bargaining agreement or participation agreement determines the Plan for which you are eligible unless otherwise determined by the Trustees.
- In general, the Tri-State Plan covers certain participants who work outside of New York City, for example in New Jersey, Connecticut, Westchester County or Long Island.

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

SECTION 1: ELIGIBILITY AND PARTICIPATION

A. Eligibility

1. When You Are Eligible

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

You are eligible for benefits under the Plan when contributions start being made to the Plan on your behalf.

Your **employer** will be required to begin making contributions to the Plan in 2024, your ton your behalf when you have completed 90 consecutive days of **covered employment** with the same **employer** working full time (as defined by your collective bargaining agreement or participation agreement).

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

For this purpose, **covered employment** includes certain leaves of absence. Days of illness, pregnancy, or injury count toward the 90-day waiting period. When you have completed that 90-day period working for your **employer**, you and your eligible dependent(s) become eligible for the benefits described in this booklet on the 91st day of **covered employment**.

As long as you are eligible, your dependent(s) are eligible, provided they meet the definition of "dependent" under the Plan (see Dependent Eligibility on pages 16-19) and you have properly enrolled them.

2. When You Are No Longer Eligible

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

- At the end of the 30th day after you no longer regularly work in **covered employment** (this does not apply if you are eligible for Fund-paid Health Extension), subject to COBRA rights. (See pages 13-15 and pages 131-136.),
- At the end of the period of Fund-paid Health Extension, subject to COBRA rights. (See pages 13-15.),
- On the date when your **employer** terminates its participation in the Plan,
- The date the Plan is terminated,
- The date that you elect to opt out of coverage if permissible under the terms of your collective bargaining agreement or
- On the date you cancel your coverage because you are eligible for Medicare. (See pages 123-124.)

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

3. If You Come Back to Work

If your employment ends after you became eligible to participate in the Plan and you return to **covered employment** (with the same **contributing employer** or a different **contributing employer**):

- Within 91 days, your Plan participation starts again on your first day back at work, or

- More than 91 days later, you would have to complete a new waiting period of 90* consecutive days of **covered employment** with the same **employer** before participation resumes.

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

B. 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.

1. COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Plan's hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision coverage. It does not include life insurance and Accidental Death & Dismemberment ("AD&D"). (See pages 131-136 for more information about COBRA.)

2. Fund-paid Health Extension

If all eligibility requirements are met, the Fund will pay for health coverage in the following situations, which are described further below:

- Disability, which must have occurred while you were in **covered employment**, and
- Arbitration, as described immediately after this section.

All periods of Fund-paid Health Extension will count toward the period for which you are entitled to continuing coverage under COBRA. Coverage for Fund-paid Health Extension includes the Plan's health (hospital, medical, behavioral health and substance abuse), prescription drug, dental and vision coverage. Life insurance and AD&D are continued only for the first six months. (See pages 97-98 for the Life Insurance Disability Extension.)

To receive Fund-paid Health Extension coverage, you must complete the COBRA Continuation of Coverage Election Form you receive in the mail. If you fail to timely return the Election Form, you may lose eligibility for continued coverage under Fund-paid Health Extension and also under

COBRA. The completed Election Form, along with all required documents (e.g., proof of disability), must be returned within the time period set forth in the COBRA Continuation of Coverage Election Form to:

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

Fund-paid Health Extension for Disability

You may continue to be eligible for up to 6 months of Fund-paid Health Extension coverage (See Fund-paid Health Extension on pages 13-14), provided you return the required documentation as described in the Fund-paid Health Extension section of the COBRA election notice, are unable to work, and are receiving (or are approved to receive) one of the following disability benefits:

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

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

- You elect to discontinue coverage;
- You work at any job;
- Six months have passed after you stopped working due to disability;
- Your Workers' Compensation or Short-Term Disability ends;
- You receive the maximum benefits under Short-Term Disability or Workers' Compensation, or
- You become eligible for Medicare as your primary insurer due to age or disability. Medicare is primary to this Plan after six months on Short-Term Disability or Workers' Compensation benefits.

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

your continued disability from time to time. Fund-paid Health Extension for disability coverage will count toward the period for which you are entitled to continuing coverage under COBRA. (See pages 131-136 for COBRA information.)

Once you are no longer eligible for Fund-paid Health Extension for disability under the Plan, your dependent(s) also are no longer eligible for benefits under the Plan, subject to COBRA rights.

If you die while receiving Fund-paid Health Extension for disability coverage, your dependent(s)' eligibility will end 30 days after the date of your death.

If a dependent is or becomes eligible for Medicare due to age or disability, Medicare is primary and this Plan is secondary for each dependent eligible for Medicare. If your dependent does not enroll in both Medicare Part A and Part B coverage, because this Plan pays as secondary, you will be financially responsible for what Medicare would have paid had your dependent properly enrolled in Medicare Part A and Part B coverage. (See coordination of benefit rules on pages 121-123.) Those covered dependent(s) who are not eligible for Medicare continue to receive primary coverage from the Fund.

Fund-paid Health Extension during Arbitration

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

3. FMLA and Other State Leave

You may be entitled to take up to a 26-week leave of absence from your job under the Family and Medical Leave Act ("FMLA"). You may be able to continue health coverage paid by your **employer** during an FMLA leave. (See page 130 for more information.) In addition, New York State, as well as other states or cities may require 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.

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

4. 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 130 for more information.) This extension of coverage will count toward the period for which you are entitled to continuing coverage under COBRA.

C. 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.

1. Eligible Dependents

You can enroll your dependent(s) if your collective bargaining agreement or participation agreement provides for dependent coverage and you enroll your dependents when you are first hired or during the open enrollment period or during a special enrollment period. Your collective bargaining agreement may require you to share in the cost of 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, which includes a marriage that is civilly annulled, your spouse is not covered). Note, your former spouse is not eligible for benefits under the Plan as your dependent. See page 18 below for more information.
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.
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 137), and • Is claimed as a dependent on your tax return.****

* Generally, a legal separation is any legally binding agreement or court order 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, property settlement agreement and annulment.

** 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 21-22.) 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, an adopted newborn child will not be covered from birth if one of the child's biological parents covers the newborn child's initial **hospital** stay, a notice revoking the adoption has been filed, or a biological parent revokes consent to the adoption.

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

**** 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.

2. 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. With the exception of COBRA coverage (see pages 13-15 and 131-136), the Plan does not permit continued coverage of your spouse if you are legally separated or divorced, even if your divorce agreement provides for continued coverage of your former spouse. It is important that you inform the Fund Office of a divorce or legal separation as soon as possible to prevent coverage of medical claims for which your former spouse is not eligible. You may be asked to repay the cost of your former spouse's medical expenses that were covered after the date of legal separation or divorce if the Fund is not informed timely. Additionally, there are other serious consequences of enrolling a person (or maintaining someone's enrollment) who is not eligible for coverage under the Plan. See Your Disclosures to the Fund: Fraud on pages 125-126.

* Generally, a legal separation is any legally binding agreement or 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, property settlement agreement, and annulment.

- Your child's eligibility ends on the earlier of the date your child (1) no longer satisfies the requirements for a dependent child as described on pages 16-18, or (2) 30 days after the child's 26th birthday, or (3) the end of the calendar year in which the child turns 26.
- Eligibility of a spouse and children (including dependent children) ends 30 days after your death.

Please see the COBRA section beginning on page 13-15 and pages 131-136 for information about continued coverage under COBRA in these situations.

D. Enrollment

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

1. How to Enroll

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 16-19 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 your dependent 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, have a baby, adopt a child) or wish to change existing dependent coverage for any reason, you must complete the appropriate form. Special rules apply regarding the effective date of your new dependent(s) coverage. (Please see Your Notification Responsibility on pages 21-22 for further details.)

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

You may also enroll your eligible dependent(s) or verify their eligibility status online via the Fund's online portal at www.32bjmemberportal.org.

2. Special Enrollment Rules

For participants working under a collective bargaining agreement that provides an annual open enrollment, depending upon the terms of that agreement, you may be permitted to enroll one or more of your dependent(s) (as defined on pages 16-19) in the same manner described above and under the section "How to Enroll" on pages 19-20 during the annual open enrollment period. After you make an election to enroll specific dependent(s) or to not enroll specific dependent(s), this election is generally fixed or locked in for the entire calendar year (January 1 to December 31). An exception applies if:

- You acquire a new dependent through marriage, birth or adoption or placement for adoption,
- You have a non-enrolled dependent who loses coverage under another group health plan (unless coverage was terminated for cause or because your dependent failed to pay premiums on a timely basis), or the **employer** stops contributing toward your dependent(s) coverage under the other plan (if your dependent elected COBRA coverage, the entire COBRA coverage period must have been completed for this rule to apply), or
- Your dependent(s) loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") or becomes eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan.

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

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

3. 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 of these dates, 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 16-19.

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 continuation of health coverage under COBRA. Please note that knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution. Additionally, you may be asked to repay the cost of the medical expenses that were covered after the date your dependent is no longer eligible for coverage if the Fund is not informed timely. Additionally, there are other serious consequences of enrolling a person (or maintaining someone's enrollment) who is not eligible for coverage under the Plan. See Your Disclosures to the Fund: Fraud on pages 125-126.

If, after your coverage under the Plan becomes effective, your dependent(s) loses eligibility for Medicaid or Childrens' Health Insurance Program ("CHIP") or becomes 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 of these dates, 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 continuation of health coverage 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.

SECTION 2: HEALTH BENEFITS (Medical, Hospital Behavioral Health and Substance Abuse) and ANCILLARY HEALTH BENEFITS (Prescription Drug, Dental and Vision)

A. Introduction

1. What Benefits Are Provided

The Fund provides a comprehensive program of health benefits, which include:

- Health Benefits including hospital, medical, behavioral health and substance abuse benefits administered by Anthem Blue Cross Blue Shield (referred to as the **claims administrator**),
- Prescription drug benefits administered by OptumRx (referred to as the **pharmacy benefit manager** or **PBM**),
- Dental benefits administered by Delta Dental (referred to as the **dental administrator**),
- Vision benefits administered by Davis Vision (referred to as the **vision administrator**), and
- Fertility benefits administered by Progyny (referred to as the **fertility administrator**).

Please refer to the Contact Chart at the back of this document for contact information, including addresses, phone numbers, and websites, for most of the above administrators.

Each of these benefits is described in the sections that follow.

2. Annual Out-of-Pocket Maximum on Health (Hospital, Medical, Behavioral Health and Substance Abuse) and Pharmacy Benefits

The annual out-of-pocket maximum is the most you would pay out-of-pocket each year. The Plan maintains separate out-of-pocket maximums for health and pharmacy benefits as well as **in-network** and **out-of-network** benefits as described below.

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

The Plan maintains an annual out-of-pocket maximum on **in-network** health (hospital, medical, behavioral health and substance abuse) and pharmacy benefits based on the guidance issued by the Department of Health and Human Services ("HHS"). 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. The annual out-of-pocket maximum for **in-network** benefits is divided between medical, which will be allocated 75% of the maximum, and prescription drug benefits, which will be allocated 25% of the maximum.

In 2024, your total individual annual **in-network** out-of-pocket maximum is $9,450, and your family's annual **in-network** out-of-pocket maximum is $18,900. If you have other family members enrolled in this Plan, they have to meet their own individual out-of-pocket limits until the overall family out-of-pocket limit has been met. The annual out-of-pocket maximum is the most you would pay out-of-pocket each year. These amounts may change from year to year.

In 2025, your total individual annual **in-network** out-of-pocket maximum will be $9,200 and your family's annual **in-network** out-of-pocket maximum will be $18,400. These amounts may change from year to year.

Annual Out-of-Pocket Maximum on In-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits

Your annual out-of-pocket maximum for individual **in-network** health benefits in 2024 is $7,088, and your family's annual out-of-pocket maximum for **in-network** health benefits is $14,175. In 2024, after a family has spent $14,175 in out-of-pocket costs for **in-network** health benefits, regardless of how much each family member paid in out-of-pocket costs for **in-network**

health benefits, there are no additional out-of-pocket costs (**copays**) for any additional **in-network** health benefits during the calendar year.

In 2025, your annual out-of-pocket maximum for individual **in-network** health benefits will be $6,900, and your family's annual out-of-pocket maximum for **in-network** health benefits will be $13,800. In 2025, after a family has spent $13,800 in out-of-pocket costs for **in-network** health benefits, regardless of how much each family member paid in out-of-pocket costs for **in-network** health benefits, there will be no additional out-of-pocket costs (**copays**) for any additional **in-network health** benefits during the calendar year.

Annual Out-of-Pocket Maximum on In-Network Prescription Drug Benefits

Your annual out-of-pocket maximum for individual **in-network** prescription drug benefits in 2024 is $2,363, and your family's annual out-of-pocket maximum for prescription drug benefits is $4,725. In 2024, after a family has spent $4,725 in out-of-pocket costs for covered prescription drugs, there are no additional out-of-pocket costs for any additional covered prescription drugs during the calendar year.

In 2025, your annual out-of-pocket maximum for individual **in-network** prescription drug benefits will be $2,300, and your family's annual out-of-pocket maximum for prescription drug benefits will be $4,600. In 2025, after a family has spent $4,600 in out-of-pocket costs for covered prescription drugs, there will be no additional out-of-pocket costs for any additional covered prescription drugs during the calendar year.

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

- **Copays**

*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,
- Expenses for non-covered services, including services that are not **medically necessary**; and
- Precertification penalties.

Annual Out-of-Pocket Maximum on Out-of-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits

Your annual out-of-pocket maximum for individual **out-of-network** health benefits in 2024 is $7,088, and your family's annual out-of-pocket maximum for **out-of-network** health benefits is $14,175. In 2024, after a family has spent $14,175 in out-of-pocket costs for **out-of-network** health benefits, regardless of how much each family member paid in out-of-pocket costs for **out-of-network** health benefits, there are no additional out-of-pocket costs (**deductibles** or **co-insurance**) for any additional **out-of-network** health benefits during the calendar year, except that this does not prevent an **out-of-network provider** from balance billing a participant for charges in excess of the **allowed amount**.

In 2025, your annual out-of-pocket maximum for individual **out-of-network** health benefits will be $6,900, and your family's annual out-of-pocket maximum for **out-of-network** health benefits will be $13,800. In 2025, after a family has spent $13,800 in out-of-pocket costs for **out-of-network** medical benefits, regardless of how much each family member paid in out-of-pocket costs for **out-of-network** health benefits, there will be no additional out-of-pocket costs (**deductibles** or **co-insurance**) for any additional **out-of-network** health benefits during the calendar year, except that this will not prevent an **out-of-network provider** from balance billing a participant for charges in excess of the **allowed amount**.

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

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

*Expenses that do not apply toward the **out-of-network** out-of-pocket maximum:*

- Premiums,
- **In-network copays**,
- Balance billing,
- Expenses for non-covered services, including services that are not **medically necessary**, and
- Precertification penalties.

Out-of-Network Prescription Drug Out-of-Pocket Maximum: There is no out-of-pocket maximum for **out-of-network** prescription drug benefits (e.g., prescriptions purchased from a **non-participating pharmacy**).

B. Health Benefits: Hospital, Medical, Behavioral Health and Substance Abuse Benefits

1. How the Health Benefit Works

The Plan provides health benefits, including hospital, medical, behavioral health and substance abuse benefits, which are administered by Anthem Blue Cross Blue Shield ("Anthem"). Anthem will be referred to as the **"claims administrator"** throughout this document. Benefits are available on both an **in-network** and **out-of-network** basis and are described in detail in this section. How much you pay out of your own pocket for covered medical expenses will depend on whether you use an **in-network** or **out-of-network provider**.

Conditions for Reimbursement

The following conditions apply:

- 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 by the Plan. The Plan will not reimburse any expenses incurred by a person while the person is not covered under the Plan.

ID Card

When you are eligible for health benefits, you will receive an ID card from the **claims administrator**. This card gives you access to thousands of **health care providers** and **facilities,** including 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.

2. In-Network Benefits

The Plan offers the Anthem Blue Cross *and* Blue Shield Point of Service ("POS") **network*** This **network** includes over 85,000 **health care 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 live outside of Connecticut and the New York and New Jersey counties identified above will receive their health (hospital, medical, behavioral health and substance abuse) benefits through the Anthem Preferred Provider Organization ("PPO") network. The PPO **network** allows participants and their dependent(s) to access **in-network benefits** through **providers** who participate in the local Blue Cross Blue Shield plan where the participant resides on the same terms as **in-network providers** under the POS **network**. (All health hospital, medical, behavioral health and substance abuse benefits described on the pages that follow are identical for the POS and PPO **networks**.)

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

Preferred facilities have the lowest out-of-pocket costs. When you use **in-network providers** including **hospitals** and **health care providers**–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 41-61 for more information on applicable **copays**.)

* 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 Anthem ID 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.

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 for **in-network** services, and no claims to file or track. In addition, **in-network providers** are responsible for obtaining any necessary pre-authorization on your behalf. (See the Pre-Authorization for Hospital, Medical, Behavioral Health and Substance Abuse section and the Schedule of **Covered Services** on pages 41–61 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**, **hospital** or **facility** is **in-network** and, if it is **in-network**, if it is **preferred** or **non-preferred**. You may ask your **health care provider**, but they do not always know whether a **facility** is a **free-standing facility** or if it is a **hospital** and if it is **preferred** or **non-preferred**, so it is always a good idea to check with the **claims administrator** before you receive services. You may also call Member Services at 1-800-551-3225 for assistance.

A listing of **in-network providers** is also available online at the **claims administrator** website (see the Contact Chart for information on the website). This directory is generally required to be updated every 90 days. If you have questions about the **network** status of a particular **provider** or **facility**, you can also contact Member Services at 1-800-551-3225.

To find an **in-network provider**:

- Go to the Find a Doctor tool on the Fund's website (www.health.32bjfunds.org), or
- Log into the Member Portal (www.32bjmemberportal.org).
- You can also chat with Member Services directly from the portal, or you can call them at 1-800-551-3225.
- To find a *5 Star Center* near you, you can call Member Services, or use the Find a Doctor tool or access the 5 Star Center maps and PDFs on the Fund's website.
- For an appointment at the Union Health Center (UHC), call 212-924-2510 or go to UHC/appointments (www.unionhealthcenter.org/appointments).

Annual Out-of-Pocket Maximum

As described at the beginning of this section, the Plan maintains an annual out-of-pocket maximum for **in-network** health (hospital, medical, behavioral health and substance abuse) benefits. After an individual or a family reaches this maximum, there will be no additional out-of-pocket costs (e.g., **copays**) for any additional **in-network** benefits for the remainder of the calendar year. Refer to the "Annual Out-of-Pocket Maximum on **In-Network** Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits" on pages 24-25 for a complete description.

Cost Transparency Tool

You can access price comparison information at the **claims administrator's** website. This tool allows you to view prices charged by a **provider**, the Plan's **allowed amounts**, your cost-sharing obligation, and other information. In order to view price information, you will need the Current Procedural Terminology (CPT) code or Diagnosis Related Group (DRG) code for the service or procedure you are looking for. This information is also available in paper format or over the phone by contacting the **claims administrator**.

Nurses Healthline

This is a free 24-hour information line for members. When you call, you can either speak to a registered nurse or select from over 1,100 audio-taped

messages in English or Spanish on a wide variety of topics. If you do not speak English or Spanish, interpreters are available through a language line. You may find it helpful to speak to a registered nurse when you need help assessing symptoms, deciding whether a trip to the emergency room is necessary or understanding a medical condition, procedure, prescription or diagnosis. You can reach the Nurses Healthline by contacting the **claims administrator** at the number found in the Contact list.

LiveHealth Online

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

3. Out-of-Network Benefits

IMPORTANT NOTE: ***Some services are not covered when you use an out-of-network provider.*** (See pages 31-35, 41-61, 80-85 and 91-95 for additional information.)

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

Care that is provided by an **out-of-network provider** is paid 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 maximum **allowed amount**. The maximum **allowed amount** is not what the **health care provider** charges you. It is the amount paid for a medical service in a geographic area based on the average county rate for facilities and the **in-network** PPO rate for **health care providers**. If you decide to stay with your choice of an **out-of-network provider**, you may have significant out-of-pocket costs. Although the Plan pays 50% of the **allowed amount**, the **out-of-network provider** may charge you more than

the **allowed amount**. In addition, you (not your doctor) must request pre-authorization for certain services when you use an **out-of-network provider**, and failure to pre-authorize will result in a financial penalty, which you will be responsible for paying.

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**. If you use an **out-of-network provider**, ask your **provider** if they will accept the **claims administrator's** payment as payment in full (excluding your **deductible** or **co-insurance** requirements). While many **providers** will tell you that they take "32BJ" or "Anthem" coverage, they don't all participate as an **in-network provider** with the **claims administrator**, so they may not accept the Plan's reimbursement 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 the **claims administrator's** payment as payment in full, it is best to get their agreement in writing.

If your **provider** does not accept the **claims administrator'**s payment as payment in full, in addition to the 50% of the **allowed amount** the plan pays, you will be responsible for charges above the **allowed amount**. See the Defined Terms (Glossary) section for a description of how the **allowed amount** is calculated. See pages 34-35 for an example of how **out-of-network providers** are paid.

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

Annual Out-Of-Pocket Maximum. As described at the beginning of this section, the Plan maintains an annual out-of-pocket maximum for **out-of-network** health (hospital, medical, behavioral health and substance abuse) benefits. After an individual or a family reaches this maximum, there will be no additional out-of-pocket costs (e.g., **deductible** and **co-insurance**) for any additional **out-of-network** benefits for the remainder of the calendar year.

The annual out-of-pocket maximum for **out-of-network** benefits is the sum of the annual **deductible** and the **co-insurance** maximum described below. Refer to the "Annual Out-Of-Pocket Maximum on **Out-of-Network** Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits" on pages 26-27 for a complete description of the annual out-of-pocket maximum.

*Annual **deductible***. Your individual annual **deductible** for **out-of-network** benefits is $1,000, and your family annual **deductible** is $2,000. 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 **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 (called "precertification penalties"), and
- Charges excluded or limited by the Plan. (See pages 42-61, 61-68, 76-77 , 86-88, 92 and 95-96.)

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 2024 **co-insurance** maximum is $6,088, and your family **co-insurance** maximum is $12,175. In 2025, your annual **co-insurance** maximum will be $5,900 and your family **co-insurance** maximum will be $11,800. 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 (precertification penalties), and
- Charges excluded or limited by the Plan. (See pages 42-61, 61-68, 80-85 , 86-88, 92 and 95-96.)

*Your Responsibilities When You Use an **Out-of-Network Provider***. You must file claims yourself when you use an **out-of-network provider**. You (not your doctor) must request pre-authorization for certain services when you use an **out-of-network provider**.

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

Example of What You Could Pay When You See an Out-of-Network Provider

Charges by **out-of-network 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 an **out-of-network provider**:

Provider Charge for Surgery	$17,000
Allowed amount for Surgery	$1,450
You pay the **deductible**	**$1,000**
You also pay 50% of the **allowed amount** after your **deductible** (**co-insurance**)	$1,450 - $1,000 = $450 $450 x 50% = **$225**
You also pay the difference between the **allowed amount** and the **provider** charge	$17,000 - $1,450 = **$15,550**
Total Amount You Owe	**$1,000 + $225 + $15,550 = $16,775**
Plan pays 50% of the **allowed amount** after your **deductible**	$1,450 - $1,000 = $450 $450 x 50% = $225
Total Amount the Plan Pays	**$225**

If you are thinking about using an **out-of-network provider**, you should call the **claims administrator** to get an idea of how much you will have to pay. In order to assist you, the **claims administrator** will need to know the **out-of-network 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 **out-of-network provider**.

4. Protections Against "Surprise Billing"

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well as the **provider** transparency requirements that are described on page 30. When you receive **emergency** care or are treated by an **out-of-network** doctor or specialist at a **hospital** or **ambulatory surgical center** that is **in-network**, you are protected by federal law from "surprise billing" or "balance billing." You are protected from balance billing for:

Emergency Services

If you have an **emergency** medical situation and receive **emergency** services from an **out-of-network** doctor, **facility** or air ambulance service, the most the doctor, **facility** or air ambulance service may bill you is the Plan's **in-network** cost-sharing amount (your **in-network copay**). You cannot be balance billed for these **emergency** services. This includes services you may

receive after you're in stable condition unless you give written consent to give up your protections against balance billing once you're stable. Any amount you pay for **out-of-network emergency services** will count towards your **in-network** out-of-pocket limit.

Certain Services at an In-Network Hospital or In-Network Ambulatory Surgical Center

When you receive services from an **in-network hospital** or ambulatory surgical center (places that perform outpatient surgeries), certain doctors or specialists there may be **out-of-network**. In these cases, the most they may bill you is the Plan's **in-network** cost-sharing amount. This applies to **emergency** medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These specialists cannot balance bill you and cannot ask you to give up your protections not to be balance billed. If you receive other services at these **in-network** facilities, **out-of-network** doctors or other **health care providers** cannot balance bill you, unless you give written consent to give up your protections.

Additionally, if you are able to show that you received inaccurate information from the **claims administrator** that a **provider** or **facility** was **in-network**, you will only be responsible for **in-network** cost-sharing amounts and these amounts will apply to your **in-network** out-of-pocket limit.

If you think you've been wrongly billed, you can contact the Employee Benefits Security Administration (EBSA) to ask whether the charges are allowed by law. Visit the Department of Labor's website (www.dol.gov/ebsa) or call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1-866-444-EBSA (3272) for more information about your rights under federal law. If you receive **emergency services** from an **out-of-network provider** or **covered services** from an **out-of-network provider** at an **in-network facility** and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the appeals procedures on pages 111-112 and 115-117.

Continuation of Care

If your **provider** ceases to be an **in-network provider** due to contract termination with the **claims administrator**, certain protections apply if you are a continuing care patient. A continuing care patient is defined as an individual who, with respect to a **provider** or **facility**, is at least one of the following:

- Undergoing treatment from the **provider** of a **facility** for a serious and complex condition, defined as:
  - in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
  - in the case of a chronic illness or condition, a condition that is:
    - life-threatening, degenerative, potentially disabling or congenital; and
    - requires specialized medical care over a prolonged period of time.
- Undergoing a course of institutional or inpatient care from the **provider** or **facility**.
- Scheduled to undergo nonelective surgery from the **provider** or **facility**, including receipt of postoperative care from such **provider** or **facility** with respect to such a surgery.
- Pregnant and undergoing treatment for pregnancy from the **provider** or **facility**.
- Terminally ill and receiving treatment for such illness from the **provider** or **facility**.

If you qualify as a continuing care patient, the Plan will notify you and you will be given the opportunity to elect to continue treatment for up to 90 days with that **provider** or **facility** as if the **provider** or **facility** were still **in-network**. If you do not properly complete and return the continuing care election form within the time periods required by the Fund, all service will be paid at the **out-of-network** rate beginning on the date the **provider** leaves the **network**.

5. Other Important Information

Benefit Maximums

There are no lifetime limits on health (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 41-61.)

Coverage When You Are Away from Home

When you are outside of the area covered by your **network**, you are covered for all **medically necessary** care on an **in-network** basis with a **copay** when using a local Blue Cross Blue Shield **in-network provider**.

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- **Prostheses**; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same cost-sharing applicable to other **in-network** and **out-of-network** medical and surgical benefits provided under this Plan, as described in this section. If you would like more information on WHCRA benefits, call the **claims administrator** or Member Services at 1-800-551-3225.

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).

6. Pre-authorization for Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits

When you use an **in-network provider**, in most instances the **provider** will do the pre-authorization for you. However, if circumstances prevent your **provider** from obtaining pre-authorization, you may be responsible for paying for the entire cost of the service if the service is not considered **medically necessary**.

If 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 the **claims administrator,** as described in this section and on page 74, or make sure that your **provider** has done so.

Failure to pre-authorize will result in a financial penalty if, after review, the services are considered to be **covered services** and are found to be **medically necessary**. You will be responsible for the entire cost of the services if, after review, they are not considered to be covered services or are not considered **medically necessary**.

For hospital/medical services that require pre-authorization, **providers** and members may call the **claims administrator** 24 hours a day, seven days a week.

For inpatient behavioral health/substance abuse services that require pre-authorization, **providers** and members may call the **claims administrator** 24 hours a day, seven days a week.

Type of Care that Requires Pre-authorization	**When You Must Call**
• Air ambulance (in non-emergency situations) • Bone Density and Echo Stress Tests • Genetic testing • Intensive **outpatient** and partial hospitalization 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 • CAR T and Gene Therapy	As soon as possible before you receive care.
Surgical procedures (*inpatient* and **outpatient**) Not all **outpatient** surgical procedures require pre-authorization. Contact the **claims administrator** to confirm if your **outpatient** procedure requires pre-authorization	Two weeks before you receive surgery or as soon as care is scheduled.
Inpatient: • Scheduled **hospital**, behavioral health or substance abuse admissions • Hospice • Admissions to skilled nursing or rehabilitation facilities	Two weeks before you receive care or as soon as care is scheduled.
• **Emergency** admissions to the **hospital**	Within 48 hours after admission.
• Maternity admissions lasting longer than two days (or four days for cesarean delivery) • Ongoing hospitalization	As soon as you know care is lasting longer than originally planned.

How pre-authorization works. The **claims administrator** 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, the **claims administrator** will make its decision not later than 72 hours after they have received all necessary information and notify you of their decision in writing. (For more information, see pages 108-117.)

*For **out-of network providers**, if you do not pre-authorize the care listed on the opposite page, 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. For **out of area in-network providers**, you are required to obtain pre-authorization for services, or you may be responsible for the entire cost.*

7. Schedule of Covered Health 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.

All services must be **medically necessary,** as determined by the **claims administrator** to be covered by the Plan.

No prior authorization is required for **emergency services** and for surgical services for which pre-authorization requirements are not permitted by applicable law.

In the Hospital and Other Inpatient Treatment Centers

Pre-authorization required for all **inpatient** admissions.

For definitions of various **facilities** and further details, see the defined terms or Glossary on pages 147-155.

In the Hospital and Other Inpatient Treatment Centers

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Additional Information and 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**. Note: 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**.	Plan pays 50% of the **allowed amount**. The member pays 50% after the **deductible** and any charges above the **allowed amount**.	Pre-authorization required. Only covered up to the semi-private room rate. If private room is used, you are responsible for the difference between the cost for a private room and a semi-private room. The additional cost does not count toward the out-of-pocket maximum, the **deductible** or **co-insurance.** The following are not covered: – Private duty nursing – Diagnostic 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, including any related **hospital** expenses or treatment of any related complications, <u>except</u> when 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 – Any part of a stay at a **hospital** or **facility** that the **claims administrator** determines does not meet the definition of **hospital** or other **facility.**
In-**hospital** services of **health care providers**			
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			
Medically necessary special diet and nutritional services			
Inpatient lab and radiology services (including high-tech radiology)		Plan pays 50% of the **allowed amount.** The member pays 50% after the **deductible** and any charges above the **allowed amount**.	
Inpatient kidney dialysis	Plan pays 100% after $100 **copay** per admission at **preferred hospitals** and $1,000 **copay** per admission at **non-preferred hospitals**. Only covered **in-network** until Medicare becomes primary for end-stage renal disease dialysis (which occurs after 30 months).	Not Covered.	

In the Hospital 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 at a 32BJ Health Fund Center of Excellence with a 32BJ Health Fund Center of Excellence **provider**. If there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address and you are granted a distance exception before your surgery, or you are granted a medical exception before your surgery, Plan pays 100% after $100 **copay** per admission at **preferred** Anthem Blue Distinction Centers of Medical Excellence and $1,000 **copay** per admission at **non-preferred** Anthem Blue Distinction Centers of Medical Excellence.	Not Covered	Pre-authorization required for all inpatient admissions. Only covered as described in the "**In-Network Hospital** or **Facility**" column. In the **claims administrator's** service area, inpatient procedures are only covered at 32BJ Health Fund Centers of Excellence facilities with 32BJ Health Fund Centers of Excellence **providers** as described in the "**In-Network Hospital** or **Facility**" column. **Outpatient** procedures are covered at any **in-network** Blue Distinction **facility**. Call Member Services for information about the 32BJ Bariatric Program.
Transplant surgery Kidney and lung transplants	Plan coverage depends on the type of transplant. In New York, only covered at Blue Distinction Centers of Medical Excellence. Plan pays 100% after $100 **copay** per admission at Blue Distinction Centers of Medical Excellence. Outside of New York, covered at any **in-network hospital**. Plan pays 100% after $100 **copay** per admission at **preferred hospitals** and after $1,000 **copay** per admission at **non-preferred hospitals**.		Pre-authorization required In New York, kidney and lung transplants are only covered at Blue Distinction Centers of Medical Excellence with a **preferred hospital copay**. Outside of New York, kidney and lung transplants are covered **in-network** only at any Blue Cross Blue Shield **in-network hospital**. Call Member Services for a list of Blue Distinction Centers of Medical Excellence.
All other transplants, regardless of location	Only covered at Blue Distinction Centers of Medical Excellence. Plan pays 100% after $100 **copay** per admission at Blue Distinction Centers of Medical Excellence.		Pre-authorization required. Other transplants are only covered at Blue Distinction Centers of Medical Excellence unless case is determined to be an **emergency**, or a **network** exception is granted by the **claims administrator**.
Lifetime travel maximum for a transplant, CAR T and Gene Therapy	Up to $10,000 per transplant.		Pre-authorization required.

In the Hospital and Other Inpatient Treatment Centers (continued)

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Joint Replacement (hip and knee)	Plan pays 100% if surgery is conducted at a 32BJ Health Fund Center of Excellence with a 32BJ Health Fund Center of Excellence **health care provider.** If there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address and you are granted a distance exception before your surgery, or you are granted a medical exception before your surgery, Plan pays 100% after $100 **copay** per admission at **preferred in-network facility** and $1,000 **copay** per admission at **non-preferred in-network facility.**	Not covered, unless there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address and you are granted a distance exception before your surgery, or you are granted a medical exception before your surgery. If there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address and you are granted a distance exception or you are granted a medical exception before your surgery, Plan pays 50% of the **allowed amount** and member pays 50% after the **deductible** and any charges above the **allowed amount**.	Pre-authorization required for all inpatient admissions. Only covered **in-network** unless criteria described in the "**Out-of-Network Hospital or Facility**" column is met. In the **claims administrator's** service area, inpatient procedures are only covered at 32BJ Health Fund Centers of Excellence facilities with 32BJ Health Fund Centers of Excellence **providers,** as described in the **"In-Network Hospital or Facility"** column. **Outpatient** procedures are covered at any **in-network facility**. Call Member Services for information about the 32BJ Joint Replacement Program. See the Physical, Occupational, Speech or Vision Therapy (including rehabilitation) for information on physical therapy after surgery.
Gender -affirming 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 any charges above the **allowed amount**.	Pre-authorization required.

In the Hospital and Other Inpatient Treatment Centers (continued)

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Skilled nursing care **facility**	Plan pays 100%.	Not Covered.	Pre-authorization required. **In-network *only***. Covered up to 60 days per calendar year. **Health care provider** 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 provider.** **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; or is a rest cure is not covered.
Hospice care **facility** and hospice services	Plan pays 100%.	Not Covered.	Pre-authorization required. **In-network *only***. Hospice care is for patients who are diagnosed as terminally ill (that is, they have a life expectancy of twelve months or less). The Plan covers hospice services when the patient's **health care provider** 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

Emergency Care

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Hospital and stand-alone Emergency room ("ER")	Plan pays 100% after $100 **copay** for first two visits, then $200 **copay** per visit. Urgent care **facilities** may bill visits as an ER visit, in which case, they will be subject to the ER **copay**.	Plan pays 100% after $100 **copay** for first two visits, then $200 **copay** per visit. For an **emergency** outside the Point of Service ("POS") Operating Area, show your ID Card when visiting a local Blue Cross Blue Shield **in-network provider**. If the **hospital** participates with another Blue Cross and/or Blue Shield program, claim will be processed by the local Blue Cross plan. If it is an **out-of-network hospital**, you must file a claim to be reimbursed for eligible expenses	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). No prior authorization is required for **emergency services** and for surgical services for which pre-authorization requirements are not permitted by applicable law. If admitted, must be pre-authorized within 48 hours of an **emergency hospital** admission.
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 any charges above the **allowed amount**.	If the urgent care center bills your visit as an Emergency room visit, you will pay the ER **copay**.
Ambulance service	Plan pays 100%.		Covered in an **emergency** and in other non-emergency situations when it is medically appropriate, as determined by the **claims administrator** (such as taking a patient home when the patient has a major fracture or needs oxygen during the trip home). Ambulette not covered. Not covered, if after **emergency** transport, you do not receive treatment services from the ER or corresponding **facility** on the same date of service. Air ambulance 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, as determined by the **claims administrator**. In all cases, the patient must be transported to the nearest **hospital** with appropriate **facilities** for treatment, and there must be a medical condition that is life threatening. Pre-authorization required for non-emergency air ambulance.

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 any charges above the **allowed amount**.	Testing must be performed within 21 days of surgery.
Surgery and care related to surgery, includes operating and recovery rooms, and services of surgeons and surgical assistants when provided in an **outpatient** department, **provider's** office or other **facility**, and medications that are part of **outpatient facility** treatment when prescribed by the **facility** and filled by the **facility's** pharmacy.	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 any charges above the **allowed amount**.	Pre-authorization required for surgical procedures, PET, CAT and nuclear imaging studies, percutaneous coronary intervention ("PCI"), cardiac catheterization and vascular ultrasound, bone density, echo stress tests, genetic testing, radiation therapy and kidney dialysis. The following services only have one **copay** per calendar year: chemotherapy, radiation therapy and hyperbaric oxygen treatment. Cosmetic surgery is not covered except when 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. With the exception of chemotherapy, routine medical care, including, but not limited to, inoculation, vaccination, drug administration or injection is not covered in an **outpatient hospital** setting unless performed in a **hospital** clinic setting.
Diagnostic procedures (such as endoscopies) and x-rays (not including high-tech imaging – see following page)			
Radiation therapy Pre-authorization required			
Chemotherapy Pre-authorization required			
Hyperbaric Oxygen Treatment Pre-authorization required			

Outpatient Treatment Facilities (continued)

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Kidney dialysis (including hemodialysis and peritoneal dialysis) Pre-authorization required		Not Covered	**In-network** only. 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. This Plan will pay as the secondary plan after the 30-month period even if not enrolled in Medicare Part B.
High-tech imaging (CAT, MRI, MRA, PET, and nuclear imaging) Pre-authorization required	Plan pays 100% after $100 **copay** at **preferred hospitals** or **freestanding facilities** or $250 **copay** at **non-preferred hospitals**. High-tech imaging has a $75 **copay** per visit at **preferred hospitals** or **freestanding facilities** for **outpatient** mental/behavioral health and substance.	Plan pays 50% the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Pre-authorization required.
Blood tests	Plan pays 100%.	Plan pays 50% of the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	
Sleep Studies	Plan pays 100% after $75 **copay** at an **in-network preferred facility**. Plan pays 100% after $250 **copay** at an **in-network non-preferred facility**.	Plan pays 50% of the **allowed amount,** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Precertification required.

Care in the Doctor's Office

Benefit	In-Network Hospital	Out-of-Network	Limitations
Office visits	Plan pays 100% for office visits with a 5 Star Center Provider. Plan pays 100% after $40 **copay** for office visits with **in-network providers**.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	
Specialist visits			
Allergy care			Limited to 12 treatment visits per calendar year, plus up to two testing visits per calendar year for allergy care.
Hearing exams			When **medically necessary**.
Chiropractic visits (See Physical, Occupational, Speech or Vision Therapy, including rehabilitation, on page 58 for more information)			Limited to 10 visits per calendar year.
Podiatric care, including routine foot care			Routine orthotics for foot care (including dispensing of surgical shoe(s) and pre- and post- operative x-rays) pertaining to routine foot care are not covered. **Medically necessary** orthotics (shoe inserts) limited to one pair per adult and two pairs per child (under age 19) per calendar year and only covered **in-network**. Nail trimmings are not covered except for patients with diabetes.
Acupuncture visits		Not Covered	**In-networ**k only. Limited to 20 visits per calendar year.
Surgery in a ***doctor's*** office	Plan pays 100%.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	
Diagnostic procedures, lab and x-rays (other than high-tech imaging, see pages, 42, and 48 for details on how high-tech imaging is covered)			

Home Health Services

Benefit	In-Network	Out-of-Network	Limitations
Home health care visits	Plan pays 100%	Not Covered	**In-network** only. Limited to 200 home care visits per calendar year, including home physical therapy, as long as **health care provider** 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 counts 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 aide services, • Restorative physical, occupational or speech therapy, and laboratory tests. Custodial services, including bathing, feeding, changing or other services that do not require skilled care are not covered.
Home hospice			**In-network** only. See "Hospice care **facility** and hospice services" for more information.
Home infusion therapy			**In-network** only. Must be arranged for by treating **provider**.
Home kidney dialysis	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**.	Not Covered	I**n-network** only. Covered at home when provided, supervised and arranged by a **health care provider** and the patient has registered with an approved kidney disease treatment center. The following are not covered: professional assistance in the home to perform dialysis, and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment. 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. This Plan will pay as the secondary plan after the 30-month period even if not enrolled in Medicare Part B.

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**. 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**.	Plan pays 50% of the **allowed amount,** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Pre-authorization required for scheduled inpatient admission.
Physician/behavioral health **provider** office visits	Plan pays 100% for office visits with a 5 Star Center **Provider**. Plan pays 100% after $20 **copay** for LiveHealth Online, and $20 **copay** for office visits with other **in-network providers**.		
Outpatient hospital facility	Plan pays 100% after $75 **copay** at **preferred hospitals**, or $250 **copay** at **non-preferred hospitals**.		Pre-authorization required for certain procedures. Contact the **Claims Administrator** to confirm if your procedure will require pre-authorization. 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.

Preventive Medical Care

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**. Some of the preventive care services that are covered are listed in the tables on the following pages. 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.

The range of preventive care services covered at no cost share when provided by **in-network health care providers** is designed to meet federal requirements. The Department of Health and Human Services decided which services to include for coverage as preventive medical care based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) Guidelines.

The following preventive services are not covered:

- Screening tests done at your place of work at no cost to you,
- Physicals for pre-employment, school, summer camp or other related activities of this nature that are in addition to physicals or well-child visits as described in this Schedule of **Covered Services**.
- Free screening services provided by a governmental health department,
- Tests done by a mobile screening unit, unless a **health care provider** not affiliated with the mobile unit prescribes the tests.

Preventive Health Services

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.		Coverage for annual exams and other preventive health services are based on age, sex, health risk factors, and preventive care guidelines. Annual exams are covered once per calendar year.
Well-woman care, which may include an annual well-woman exam and screening for cervical cancer, pregnancy-related screenings, and reproductive-health screenings	If in an office or **freestanding 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 any charges above the **allowed amount**.	
Preventive procedures (e.g., mammogram, colonoscopy)			
Well-child care provides for regular check-ups and preventive health services, and immunizations			Well-child visits are subject to the frequency limits listed below and preventive health services based on age: **Number of Visits/Age Range:** 1 exam at birth/ Newborn 6 visits/ Under 1 7 visits/ 1–4 yrs. old 7 visits/ 5–11 yrs. old 6 visits/ 12–17 yrs. old 2 visits/ 18–19 yrs. old
Routine immunizations – all ages (includes travel immunizations)	Plan pays 100% – $0 **copay.**	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Coverage for immunizations is based on age, health risk factors and preventive care guidelines.
Nutritional counseling for preventive care			Unlimited

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 the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Reversal of vasectomy not covered. Reversal of sterilization not covered. Reversal of tubal ligation not covered.
Vasectomy (excludes reversal)	Plan pays 100% after **copay** based on where service is provided: If in an office or independent **freestanding 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 non-elective procedures			

Reproductive Health Services (continued)

Benefit	In-Network	Out-of-Network	Limitations
Travel expenses benefit for abortion	Up to $2,000 per abortion.	Not Covered.	If you are unable to receive an abortion in the state in which you reside due to state law restrictions and you choose to travel to another state where you can receive abortion care services legally, the Fund will reimburse your travel expenses to the extent not prohibited by law. Only travel expenses incurred to access **in-network** abortion care are covered. To find an **in-network provider**, contact Member Services at 1-800-551-3225. Travel expenses to access **out-of-network** abortion care are not covered. Travel expenses for up to two people (the patient and a companion) may include, as applicable, expenses for airfare, mileage, and lodging, subject to limitations under the Internal Revenue Code. Travel expenses do not include meals. Contact the **claims administrator** for additional information about limitations applicable to the travel benefit.
Fertility Testing	Plan pays 100% after **copay**, based on where service is provided: If in an office or **freestanding facility** – $0 **copay**. If in an **outpatient preferred hospital** setting – $75 **copay**. If in an **outpatient non-preferred hospita**l setting – $250 **copay**.	Plan pays 50% of the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Fertility testing limited to once per calendar year.
Fertility Treatment	Not Covered under your Medical Benefit. Please see "Fertility Benefits Through Progyny" section on pages 93-96.	Not Covered under your Medical Benefit. Please see "Fertility Benefits Through Progyny" section on pages 93-96.	No coverage for treatment of infertility under your Medical Benefit. Please see "Fertility Benefits Through Progyny" section on pages 93-96.

Pregnancy, Maternity and Newborn Care

Benefit	In-Network	Out-of-Network	Limitations
Office visits for prenatal and postnatal care from a **health care provider** or certified nurse-midwife, including diagnostic procedures	Plan pays 100% for office visits with a 5 Star Center provider. For a non-5 Star Center Provider, Plan pays 100% after initial $40 **copay**. No **copay** for postnatal visit.	Plan pays 50% of the **allowed amount,** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	**Copays** for prenatal visits are limited to one **copay** per pregnancy, upon confirmation of pregnancy. Services of a doula and semi-private nursing care are not covered.
Newborn in **hospital** nursery	Plan pays 100%.		
Obstetrical care admission in **hospital**	Plan pays 100% after $100 **copay** for admission at a **preferred hospita**l 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 the Maternity Program **copay** is waived and Plan pays 100%.	Plan pays 50% of the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Call Member Services for information on the 32BJ Maternity Program. Only covered up to the semi-private room rate. If private room is used, the member is responsible for the difference between the cost for a private room and a semi-private room. The additional cost does not count toward the out-of-pocket maximum, the **deductible** or **co-insurance**.
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.
Breast pump	Plan pays 100% for two covered models only when obtained from www.edgepark.com.	Not Covered.	Two breast pumps per pregnancy within a 270-day period. Breast pump coverage limited to two identified models when obtained from Edge Park.

Pregnancy, Maternity and Newborn Care (continued)

Benefit	In-Network	Out-of-Network	Limitations
Home birth with a certified nurse-midwife	Plan pays 100%.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Prior authorization is required for use of an **out-of-network** nurse midwife for home birth.
A **home health care** visit		Not Covered.	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.
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 any charges above the **allowed amount**.	

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

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 any charges above the **allowed amount.**	Pre-authorization required. Covered up to 30 days per calendar year. Only covered up to the semi-private room rate. If private room is used, the member is responsible for the difference between the cost for a private room and a semi-private room. The additional cost does not count toward the out-of-pocket maximum, the **deductible** or **co-insurance**. Therapy to maintain or prevent deterioration of the patient's current physical abilities are not covered.
Doctor's office	Plan pays 100% for office visits with a 5 Star Center Provider.		Pre-authorization required for physical and occupational therapy.
Outpatient facility	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**. **Copay** is waived for physical therapy at a **freestanding facility** received within the first 50 days after **hospital** discharge for a total joint replacement (hip or knee) surgery that was performed at a 32BJ Health Fund Center of Excellence with a 32BJ Health Fund Center of Excellence doctor.	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. Covered if prescribed by **health care provider** and designed to improve or restore physical functioning within a reasonable period of time. For **outpatient** physical and occupational therapy, your **in-network** therapist will pre-authorize services required after your first assessment visit.
Services in the home	Plan pays 100%		Pre-authorization required. **In-network** only. Limited to 200 visits per calendar year for all home visits, including home physical therapy visits.

Durable Medical Equipment, Prosthetics and Non-Durable Medical Equipment and Supplies

Providers of **durable medical equipment, prosthetics** and **non-durable medical equipment** and supplies outlined in this section may not be the same as **hospital**/medical **providers**. Contact Member Services to ensure you receive equipment and supplies from an **in-network provider**.

Benefit	In-Network	Out-of-Network	Limitations
Durable medical equipment (DME) including: wheelchairs, nebulizers, oxygen equipment, sleep apnea monitors and **hospital**-type beds	Plan pays 100%.	Not Covered.	Pre-authorization required. **In-network** benefit only. Must be prescribed by a **health care provider**. Includes renting, buying (if less expensive than long-term rental or when the item is not available on a rental basis), reasonable cost of repairs and maintenance and/or repair because of wear, damage, growth or change in the patient's need when ordered by a **health care provider**. The following are not covered: – Air conditioners or purifiers – Humidifiers (except as needed with CPAP machine) or dehumidifiers – Exercise equipment – Swimming pools. Must be obtained from an **in-network** vendor. Contact Member Services or the **claims administrator** to ensure you receive your equipment from an i**n-network** vendor and for a complete list of covered benefits.
Prosthetics and orthotics including: artificial arms, legs, eyes, ears, nose, larynx and external breast **prostheses,** supportive devices essential to the use of an artificial limb and corrective braces	Plan pays 100%.	Not Covered.	Pre-authorization required. **In-network** benefit only. Must be prescribed by a **health care provider**. Includes renting, buying (if less expensive than long-term rental or when the item is not available on a rental basis), reasonable cost of repairs and maintenance and/or repair because of wear, damage, growth or change in the patient's need when ordered by a **health care provider**. Foot orthotics for routine foot care (including dispensing of surgical shoe(s)) are not covered. Foot inserts are covered only for non-routine foot conditions – limited to one pair per adult and two pairs per person under age 19 in a calendar year. Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, is not covered. Must be obtained from an **in-network** vendor. Contact Member Services or the **claims administrator** to ensure you receive your equipment from an **in-network** vendor and for a complete list of covered benefits.

Durable Medical Equipment, Prosthetics and Non-Durable Medical Equipment and Supplies (continued)

Benefit	In-Network	Out-of-Network	Limitations
Non-durable medical equipment and diabetic supplies (such as catheters and syringes)	Plan pays 100% when using a **durable medical equipment provider**	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	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-ridged cervical collars or surgical shoes are not covered. Must be obtained from an **in-network** vendor. Contact Member Services or the **claims administrator** to ensure you receive your equipment from an **in-network** vendor and for a complete list of covered benefits.
Wigs	Plan pays 100%	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Covered following chemotherapy or radiation therapy and in other limited circumstances, such as alopecia, lupus, burns and wounds of the scalp. Contact the **claims administrator** for additional information.
Nutritional supplements that require a prescription (including, but not limited to: enteral formulas, including infant formulas, and modified solid food products)	Plan pays 100% when using a **durable medical equipment provider**.	Plan pays 50% of of the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Nutritional supplements covered when the **health care provider** issues a written order that states the formula is **medically necessary** and has been proven effective as a disease-specific treatment regimen for the patient's condition. Modified solid food products covered for the treatment of certain inherited diseases if the patient has a written order from a **health care provider**. Supplements and formulas taken by healthy patients or taken electively (those taken without a **provider's** written order that states the formula is **medically necessary** and has been proven effective as a disease-specific treatment regimen for the patient's condition) are not covered. Formulas for healthy infants, such as Enfamil, Enfamil with Iron, Similac and Similac with Iron, are not covered. Not covered under the Prescription Drug Benefit. Must be obtained from an **in-network** vendor. Contact Member Services or the **claims administrator** to ensure you receive your equipment from an **in-network** vendor and for a complete list of covered benefits.

Durable Medical Equipment, Prosthetics and Non-Durable Medical Equipment and Supplies (continued)

Benefit	Network	Out-of-Network	Limitations
Hearing aids	Plan pays 100%.	Not Covered.	Pre-authorization required. **In-network** benefit only through a designated **in-network** hearing aid **provider**. Call Member Services for information on the **claims administrator's** designated hearing aid **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.

Dental Care Covered Under Medical Benefit

Dental care is also covered under the Plan's dental benefit described on pages 77-90 of this SPD. When a dental procedure is eligible for coverage under both your health (hospital, medical, behavioral health and substance abuse) plan and the dental plan, your health (hospital, medical, behavioral health and substance abuse) plan will always be the primary payor.

Benefit	In-Network	Out-of-Network	Limitations
Surgical removal of impacted wisdom teeth only Repair to natural teeth after injury	Plan pays 100% after **copay**: If in an office or **freestanding facility**–$0 **copay**. If in **outpatient preferred hospital** setting–$75 **copay.** If an **outpatient non-preferred hospital** setting–$250 **copay**.	Plan pays 50% of the **allowed amount**, and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Only covered if the repair is performed within 12 months of injury to sound natural teeth.

8. Excluded Health (Hospital, Medical, Behavioral Health and Substance Abuse) Expenses

In addition to the exclusions set forth in the Schedule of **Covered Services** and elsewhere described in this document, the following expenses are not covered under the health (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 the health (hospital, medical, behavioral health and substance abuse) benefits 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* or elective *cosmetic surgery* at any related **hospital** or **facility.** Other medical expenses or treatment for any related complications, except when necessitated by injury, or for breast reconstructive surgery, performed as treatment for gender dysphoria, or is necessary to lessen a disfiguring disease or deformity arising from, or directly related to, a congenital abnormality,
- Technology, treatments, procedures, drugs, biological products or medical devices that in the **claims administrator's** judgment are **experimental, investigative**, obsolete or ineffective. Also excluded is any hospitalization in connection with **experimental** or *investigational* treatments. **Covered services** incurred as part of a clinical trial will be covered to the extent required by applicable law.
- Except as otherwise specified, expenses for the treatment of fertility including any and all assisted reproductive technologies (treatment of infertility is not covered under your Medical Benefit; refer to the Fertility Benefits Through Progyny section on pages 93-96 for a description of benefits available under that program).
- 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 over-the-counter 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 Nutrisystem,
- Operating room fees for surgery, surgical trays and sterile packs done in a non-state-licensed **facility** including the **provider's** office,
- Orthotics for routine foot care (including dispensing of surgical shoe(s)),
- Routine hearing exams for adults,
- Formal psychological evaluations and/or fitness-for-duty opinions that are part of a pre-employment physical or done in connection with a physical for school, camp, or other related activity,
- Training or educational therapy for reading or learning disabilities,
- Testing, screening or treatment for learning disorders, expressive language disorders, mathematics disorders, phonological disorders and communication disorders,
- Services for treatment of intellectual disabilities
- Treatment for conditions not listed as mental disorders in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders,*
- 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 pre-employment, school, summer camp or other related activities of this nature that 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 **health care provider** not affiliated with the mobile unit prescribes the tests.

- The following specific **emergency services**:
  - use of the emergency room to treat non-emergent ailments because you have no regular **health care provider** or because it is late at night, a weekend or a holiday (and the need for treatment does not meet the Plan's definition of **emergency**.) (See pages 148-149.)
  - 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,
  - **hospital** services received in clinic settings that do not meet the **claims administrator's** definition of a **hospital** or other covered **facility,**
  - bariatric surgery performed by a **health care provider** that is not part of the 32BJ Health Fund Center of Excellence program, and performed at a **facility** that is not a 32BJ Health Fund Center of Excellence or Blue Distinction Center of Medical Excellence (or a Blue Distinction Center of Medical Excellence to the extent that the

Plan approved the use of such center) when no medical or distance exception is granted.

  - inpatient joint replacement surgery performed by a **health care provider** that is not part of the 32BJ Health Fund Center of Excellence program, and performed at a **facility** that is not a 32BJ Health Fund Center of Excellence or Blue Distinction Center of Medical Excellence unless there is no 32BJ Health Fund Center of Excellence within 50 miles of the patient's home address and the patient is granted a medical or distance exception, as applicable, before the surgery,

- The following specific **outpatient hospital** care expenses:
  - with the exception of chemotherapy, routine medical care including, but not limited to, inoculation, vaccination, drug administration or injection, unless performed in a **hospital** clinic setting,
  - collection or storage of your own blood, blood products or semen.
- All excluded **out-of-network** services,
- The following specific equipment:
  - air conditioners or purifiers,
  - humidifiers (except when needed with 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 90-92 to find out how eyeglasses and contact lenses may be covered under the vision benefit.
  - routine vision care (See Vision Care Benefits on pages 90-92 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 page 61 and pages 77-90,
  - 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 23-27 and 69-77 to find out how prescription drug expenses may be covered.
  - false teeth (also called dentures) (not covered under health (hospital, medical, behavioral health and substance abuse) benefits, but may be covered under dental.) (See Dental Benefits on page 61, and pages 77-90.)
- 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 126-129),

- 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 126-129).
- 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 the **claims administrator** 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 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,
- charges for services that are not rendered.

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 hospitals or facilities:***

- kidney dialysis,
- bariatric surgery or total joint replacement surgery performed at a **hospital** that is not at a 32 BJ Center of Excellence or Blue Distinction Center of Medical Excellence in the **claims administrator's network** when a medical or distance exception has not been granted,
- inpatient transplant surgery for bone marrow, liver, heart and pancreas performed at a **hospital** that is not a Blue Distinction Center of Medical Excellence unless case is determined to be an **emergency** or a **network** exception is granted by the **claims administrator**.
- transplant surgery for kidney and lung performed in New York at a **hospital** that is not a Blue Distinction Center of Medical Excellence,
- transplant surgery for a kidney or lung transplant performed at an **out-of-network hospital,**
- **skilled nursing facility,**
- **home health care,**
- hospice care **facility,**
- home infusion therapy,
- birthing centers,
- **outpatient** physical, occupational, speech, and vision therapy,
- **durable medical equipmen,t**
- **prosthetics**/orthotics,
- hearing aids, and
- charges for services that are not rendered.

C. Prescription Medication Benefit

1. How the Prescription Medication Benefit Works

The Plan provides a prescription medication benefit, which is administered by Optum Rx ("Optum"). Optum will be referred to as the "**pharmacy benefit manager**" or "**PBM**" throughout this document. The list of medications that are covered by your Plan is known as a "formulary." The formulary includes specific generic, brand-name and specialty medications. All prescription medications must be **medically necessary**.

The **pharmacy benefit manager's network** of **participating pharmacies** is very broad and includes almost all pharmacies where you fill a prescription. **Participating pharmacies** are those that are **in-network**. You must get your prescriptions filled at a **participating pharmacy**. The Fund does not provide coverage for prescriptions filled at **non-participating pharmacies** (**out-of-network**).

To find a **participating pharmacy** call the **pharmacy benefit manager**.

2. Types of Out-of-Pocket Costs for Prescription Medication

Pharmacy Type	Drug Type	Regular Copay	5 Star Wellness Program Copay (see below)	Restrictions
Retail Pharmacy Your short-term medications can be filled at a retail pharmacy or through OptumRx Mail Order Pharmacy.	Generic Medications	$10 **copay**	$5 **copay**	– Maximum day supply is 30-day, or 28-day supply for weekly medications. – Limited to two fills of the same medication. After two fills, you must fill a 90-day supply at either CVS Pharmacy or OptumRx Mail Order Pharmacy. – No coverage at **non-participating pharmacy.**
(OptumRx Mail Order Pharmacy is also called Mail Order Pharmacy and OptumRx Home Delivery.)	Brand-name Medications	$30 **copay**	$5 **copay**	

Types of Out-of-Pocket Costs for Prescription Medication (continued)

Pharmacy Type	Drug Type	Regular Copay	5 Star Wellness Program Copay (see below)	Restrictions
Retail 90 (90-day supply filled at CVS Pharmacy) Your maintenance medication may be filled at a retail CVS Pharmacy. Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes	Generic Medications	$20 **copay**	$10 **copay**	– Must fill a 90-day supply (84-day for weekly dosage). – Limited to CVS Pharmacy. – No Retail 90 coverage at any other **participating pharmacy.**
	Brand-name Medications	$60 **copay**	$10 **copay**	
Mail Order Pharmacy Your maintenance medication also may be filled at the Mail Order Pharmacy. You may also fill a short-term medication at the Mail Order Pharmacy. Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes.	Generic Medications	$20 **copay**	$10 **copay**	– Maximum day supply is 90 (84-day for weekly dosage) – Limited to OptumRx Mail Order Pharmacy – No coverage at **non-participating pharmacy**
	Brand-name Medications	$60 **copay**	$10 **copay**	
Specialty Pharmacy Your specialty medications must be filled at the Specialty Pharmacy. Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like rheumatoid arthritis, multiple sclerosis, and cancer.	Specialty Medications	$30 **copay**	$5 **copay**	– Limited to Optum® Specialty Pharmacy – No coverage at any other **participating pharmacy** and at any **non-participating pharmacies** – Most specialty medications maximum day supply is 30-day supply or a 28-day supply for weekly medications

Notes: No **copay** required for diabetic test strips, most contraceptive prescriptions and certain preventive over-the-counter medications prescribed for you. (See Eligible Drugs on pages 76.) In addition, if the cost of the medication is less than the **copay**, you pay the cost of the medication.

Your Plan's formulary is mandatory generic, which means that you generally must receive the generic version of a prescribed medication. The formulary includes a wide selection of generic medications. The formulary also includes brand-name medications that do not have a sufficient number of generic alternatives. In most instances, when a generic is available, if the pharmacy dispenses a brand-name medication, you will pay the difference between the brand-name medication and the generic plus the brand-name **copay**. If your **health care provider** prescribes a covered brand-name medication and prevents the pharmacy from dispensing an interchangeable generic (e.g., selects "Dispense As Written" ("DAW")), you will pay the difference between the brand-name medication and the generic plus the brand-name **copay**.

If you or your **health care provider** want to know whether a drug is on the formulary, you can call the **pharmacy benefit manager** or visit their website.

Your maximum annual out-of-pocket limit for **in-network** (***participating***) prescription medication **copays** in 2024 is $2,363 for an individual and $4,725 for a family.* In 2025, your maximum annual out-of-pocket limit for **in-network** (***participating***) prescription medication **copays** will be $2,300 for an individual and $4,600 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.

3. 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 discounted **copays**. 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.

* 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.

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

4. Ways to Get Your Prescriptions Filled

Short-term Medications

Short-term medications are prescriptions used to treat acute conditions for a specific period of time. These conditions usually require short-term use of medicine. An example of a short-term drug is antibiotics.You can have your short-term medication prescription filled at a *participating retail pharmacy* or through the Mail Order Pharmacy.

Maintenance Medications

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions often require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes. Your pharmacy benefits cover the first two 30-day fills (or 28-day fills for weekly medications) of a maintenance medication at a retail pharmacy or through the Mail Order Pharmacy as described on the previous pages. If you need to take a maintenance medication on an ongoing basis for more than 60 days, the maintenance medication must be filled at a 90-day supply either:

1. at a CVS pharmacy, or

2. through the Mail Order Pharmacy.

The Plan does not cover maintenance medications after the first two 30-day fills (or 28-day fills for weekly medications) at any other pharmacy.

If you are stopping a maintenance medication and need less than a 90-day supply for your last fill, please contact the **pharmacy benefit manager** for information on how to get your last fill. To use the Mail Order Pharmacy, call the **pharmacy benefits manager** or visit their website.

Specialty Medications

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.

Your pharmacy benefits cover specialty medications that are on the **pharmacy benefit manager's** formulary. Most specialty medications must be filled at a 30-day supply (or 28-day supply for weekly medications) through the Specialty Pharmacy.

If a specialty medication is on the **pharmacy benefit manager's** formulary and available through the Specialty Pharmacy, the Plan will not cover the specialty medication if you fill it at a non-Specialty Pharmacy even if it is a **participating pharmacy**. The Plan does not cover specialty medications filled at a **non-participating pharmacy**. For information on how to fill a specialty medication call the **pharmacy benefit manager** or register online at their website.

The Plan does not cover maintenance medications or specialty medications filled at pharmacies other than those listed on page 70, and pages 72-73. If you have a prescription filled for a drug requiring prior authorization or that is subject to quantity limits or step therapy and your **health care provider** fails to obtain approval before you fill the prescription, you may be responsible for the full cost of the prescription drug.

Copay Card Program

Many manufacturers offer **copay** coupons to help offset costs. The Copay Card Program may reduce your **copay** to $0 at the Specialty Pharmacy and through the Mail Order Pharmacy. Drug coupon dollars will not count toward your out-of-pocket limit.

You must enroll in the program to receive your **copay** discount. For information on how to enroll call the **pharmacy benefit manager** and ask about the "Variable **Copay** Savings Program".

5. Prescription Plan Coverage Management Programs

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

Prior Authorization

Certain medications on the Plan's formulary require prior authorization before your prescription will be covered under the Plan. Drugs subject to prior authorization include those products that are commonly subject to overuse, misuse or off-label use, subject to significant safety concerns, or are very expensive. Please note you may have to pay the entire cost of the prescription if you do not get prior authorization before filling a prescription; these claims will not be reimbursed. The Prior Authorization Program is administered by the **pharmacy benefit manager** to determine whether your use of certain medications meets the Plan's conditions for coverage and the **pharmacy benefit manager's** clinical guidelines for use of the specific drug. Your prescriber will need to contact the **pharmacy benefit manager's** Prior Authorization Department to provide the necessary clinical information to determine the appropriateness of the medication for you 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 of time. You'll be told how long the approval is good for.

Step Therapy

The Step Therapy Program ensures 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 alternative brand-name medication. This helps to keep prescription costs low. When you present a prescription for certain medications to your pharmacist, the **pharmacy benefit manager** 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 alternative brand-name medication, your prescription may be approved and filled as written. If there is no history of your use of a generic or alternative brand-name medication, the pharmacist will receive a message for your prescriber to call a toll-free number for more information. Your prescriber will be asked to prescribe a generic or alternative brand-name medication before other drugs are covered.

In the event that your prescriber advises the **pharmacy benefit manager** that a generic or alternative brand-name medication is not right for you, your prescriber can then call the **pharmacy benefit manager's** Prior Authorization Department to seek approval for the other medication.

Quantity Limits

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

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

Specialty Split Fill for Certain Oral Oncology Medications

Often **health care providers** change or discontinue certain oral oncology medications. If you are taking one of those medications, the 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 **health care provider** may prescribe you a medication that is not covered on the formulary. You or your **health care provider** may request a **medical necessity** review through the **pharmacy benefit manager** to seek approval for the medication.

If the medication that is approved and dispensed is a brand-name drug, and there is a generic on the formulary, you will have to pay the brand-name **copay** and the difference in cost between the brand-name and the generic drug.

6. 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 or if generic is medically inappropriate. Brand-name contraceptives with generics available will be subject to the brand-name **copay**,
- Prenatal vitamins, with no **copay** required,
- Immunizations based on age and health-risk factors, and
- Four over-the-counter COVID test kits per month per covered individual obtained from a **participating pharmacy** or up to four over-the-counter COVID test kits per month per household through the **pharmacy benefit manager's** store, with no **copay** required through August 31, 2024. Beginning September 1, 2024, over-the-counter COVID test kits are no longer covered under the Plan.

7. Excluded Drugs

The following are not covered under the Plan:

- Prescriptions filled at **non-participating pharmacies**,
- Prescription drugs that are not **medically necessary**,
- Most over-the-counter drugs and vitamins (except for certain vitamins for prenatal care and over-the-counter COVID test kits under certain circumstances – see above for information),
- Prescription drugs subject to prior authorization, step therapy, or quantity limits for which your **health care provider** has not received authorization,

- Drugs used in clinical trials or **experimental** studies (except that covered drugs used in clinical trial will be covered to the extent required by applicable law),
- Drugs used for fertility treatment or egg donation not covered under your prescription medication benefit; please see Fertility Benefits Through Progyny section on pages 93-96 for information on what drugs are covered under that program,
- Drugs prescribed for cosmetic purposes unless **medically necessary**,
- Drugs used for weight loss unless you meet the Plan's medical criteria,
- Non-formulary drugs, unless your **health care provider** can establish **medical necessity,**
- Therapeutic devices or appliances, support garments and other non-medical substances, and
- Prescription drugs that an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state or federal program.

D. Dental Benefits

1. How the Dental Benefit Works

The Plan provides coverage for necessary dental care received through:

- A **participating** dentist,
- A non-participating dentist,
- The 32BJ Dental Center at 25 West 18th Street, New York, NY 10011-4676.

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

- 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.

Annual Maximum

The Dental Plan provides an annual maximum coverage amount per participant or dependent age 19 and older per calendar year for covered dental services.

The Dental Plan will cover up to $1,000 and an extra $500 if **covered services** are provided by a **participating provider**. There is no annual maximum for those under age 19.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services.

2. Participating Dental Providers

The 32BJ Dental Center

The 32BJ Dental Center provides a broad range of dental services, except those that require general anesthesia. When you use the 32BJ Dental Center, the Plan provides coverage at 100% for all care you receive at the 32BJ Dental Center and you will not have to pay for any of the care. The 32BJ Dental Center has a limited capacity and when it reaches the maximum number of patients it can serve, it will temporarily suspend accepting new patient appointments.

Dentists who participate in the **network** that covers you have agreed to accept the amount that the **dental administrator** pays along with your cost share as payment in full for covered dental care that you receive. Refer to the Schedule of Covered Dental Services for more information on costs associated with dental services.

To find a **participating dentist**, use the Find a Dentist feature on the 32BJ Member Portal www.32bjmemberportal.org or call Member Services at 1-800-551-3225. You can also contact the dedicated 32BJ number for the **dental administrator** or visit their website.

Your dental network is the PPO **network**. Any dental services provided by a dentist not in the PPO **network** will be covered as an **out-of-network** benefit.

3. Non-Participating Dentists

You have coverage for dental work performed by any licensed **non-participating dentist**. See the Schedule of Covered Dental Services for coverage and payment details. Services provided by **non-participating dentists** are also called "**out-of-network** benefits." Amounts above the **allowed amount** are not eligible for reimbursement and are your responsibility to pay.

You will be required to initially pay a **non-participating dentist's** full charges. You will then file a claim with the **dental administrator** (see pages 103-104) and will be reimbursed according to the applicable **dental administrator** fee schedule for each procedure.

Your non-participating dentist can find out the **dental administrator's** reimbursement allowance by submitting a predetermination request to the **dental administrator**.

4. Predeterminations/Pretreatment Estimates

Predeterminations are free and help you and your dentist make informed decisions about your treatment. Your dentist will receive an estimate of what the **dental administrator** will pay and what your out-of-pocket expenses, including any **copays**, will be.

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, the **dental administrator** recommends that you request a pretreatment estimate before starting services. Pretreatment estimate requests are not required; however, the **dental administrator** recommends requesting a pretreatment estimate for more complicated and expensive procedures such as for crowns, wisdom teeth extractions, bridges, dentures, or periodontal surgery.

5. Schedule of Covered Dental Services

The Plan does not cover benefits for procedures that are not listed in the Schedule of Covered Dental Services but may cover an alternate benefit if approved by the **dental administrator** on behalf of the Dental Plan. What you pay depends on whether you receive your dental care from a **participating dentist**, or a **non-participating dentist**.

Preventive Services

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

Diagnostic Services

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Oral exam, periodic, limited (problem focused), comprehensive or detailed and extensive (problem-focused)	Two in a calendar year.	Plan pays 100%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
X-rays: • full mouth, complete series, including bitewings or panoramic film	Once in any 36-consecutive-month period.		
• Bitewings, back teeth	Two of any *bitewing* (top and bottom back teeth together) or back teeth (top OR bottom alone) x-ray procedure in a calendar year.		
• Periapicals, single tooth	As necessary.		
• Occlusal film	Two per date of service.		

Simple Restorative Services

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
• Amalgam (metal) fillings • Resin (composite, tooth-colored) fillings on anterior teeth	Once per tooth surface in any 24-consecutive-month period.	Plan pays 80% and member pays 20%.	Plan pays lesser of actual charges or 50% of the **allowed amount,** and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.

Endodontics

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
• 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 • Hemisection*	Once per tooth in a lifetime.	Plan pays 80% and member pays 20%.	Plan pays lesser of actual charges or 50% of the **allowed amount,** and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
• Apexification/Recalcification*	Once per tooth in a lifetime. Only for children under age 19.		
• Pulp Capping	Once per tooth within a 12-month period.		

* These services are not performed in the 32BJ Dental Center. 32BJ Dental Center patients will be referred to a **network** specialist.

Periodontics

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
• Gingivectomy or gingivoplasty • Osseous surgery* Periodontal scaling and root planing	Once per quadrant in a 60-consecutive-month period. Once per quadrant in a 24-consecutive-month period.	Plan pays 80% and member pays 20%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
Periodontal maintenance (procedure is a benefit following active periodontal therapy once a 30-day post-operative period has been completed)	Two of any prophylaxis procedures in a calendar year.		

Simple Extractions

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Once per tooth in a lifetime.	Plan pays 80% and member pays 20%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.

Oral and Maxillofacial Surgery

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

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
• Extractions • Removal of impacted tooth, residual tooth roots*	Once per tooth in a lifetime.	Plan pays 80% and member pays 20%	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)	Once per quadrant in a lifetime.		
Frenulectomy*	Once per arch in a lifetime.		

* These services are not performed in the 32BJ Dental Center. 32BJ Dental Center patients will be referred to a **network** specialist.

Major Services

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Recementation of crown, inlay, onlay	Once per tooth in any calendar year	Plan pays 50% and member pays 50%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
Prefabricated stainless steel/ resin crown (for children only– deciduous (baby) teeth only)*	Once per tooth in any 24-consecutive-month 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-month period.		

Removable Prosthodontics

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

Fixed Prosthodontics

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

* These services are not performed in the 32BJ Dental Center. 32BJ Dental Center patients will be referred to a **network** specialist.

Repairs

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Crown repair	Once per tooth in a 24-consecutive-month period.	Plan pays 50% and member pays 50%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
Repair, Adjustment or Additions to partial dentures	Twice in any consecutive 12-month period.		
Replace broken teeth on denture			

Emergency Treatment

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

Miscellaneous Dental

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Bite guard	One appliance in any 60-consecutive-month period	Plan pays 100%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.
Nitrous Oxide	Only for children under age 19.	Plan pays 100% after a **copay** of $10.	Not Covered.

Orthodontic Services*

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Orthodontics	Only for children under age 19. Plan pays 50%, up to 50% of lifetime maximum, for multiyear course of treatment started at age 18. One course of treatment*** in a lifetime.	Plan pays 100% up to lifetime maximum** of $2,500. One course of treatment*** in a lifetime. Only for children under age 19. At the time the appliance is inserted the plan pays up to 50% of the lifetime maximum. The plan pays the remaining amount (up to 50% of the lifetime maximum) at the start of the second year for children under age 19. If a course of treatment is started at age 18, the plan will only pay up to 50% of the lifetime maximum for the entire course of treatment.	Not Covered
Cephalometric film or photographic image obtained intra or extra-orally (orthodontic coverage only)			

* Benefits are payable only for treatment overseen and provided by a licensed dentist or orthodontist. No benefits are available for do-it-yourself or mail-order programs or any services not overseen and provided by a licensed dentist or orthodontist.

** There is no lifetime limit on the following **medically necessary** orthodontic services: procedures that 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.

6. 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. In all cases in which there are optional or alternative plans of treatment carrying different treatment costs, the Plan will generally limit benefits to the least expensive method of treatment that is appropriate and that meets acceptable dental standards, so long as such treatment will restore the oral condition in a professionally accepted manner. Any differences in treatment cost will be the responsibility of the patient. 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. Optional or alternative treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

7. What Is Not Covered

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

- 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-network** orthodontic care for individuals under age 19,
- Charges in excess of the **allowed amounts**, or the annual maximum, or the lifetime maximum for orthodontic care,
- Treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accidental injury,
- Services or supplies that the Plan determines are **experimental** or investigative in nature, except to the extent provided by law,

- Services or treatments that the Plan determines do not have a reasonably favorable prognosis,
- 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, unless can be provided with an alternate benefit as described in the section entitled Alternate Benefit for Dental Coverage on the prior page.
- 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.
- 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 69-77.)
- 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,
- Procedures not listed under the Schedule of Covered Dental Services or the Schedule of Covered Dental Services for the Delta Dental PPO Plan, and
- Charges for services not rendered.

8. Coordination of Dental Benefits

When this Plan's coverage is primary, the **dental administrator** pays benefits under this Plan as if there is no other coverage. When this Plan is secondary and there are remaining expenses of the type allowable under this Plan, the **dental administrator** 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," the **dental administrator** will determine its benefits first. If such determination indicates that this Plan should not have been the first program to determine its benefits, this Plan 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 this Plan is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When this Plan is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, this Plan will pay only the amount by which 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 health (hospital, medical, behavioral health and substance abuse) plan and your dental plan, your health (hospital, medical, behavioral health and substance abuse) plan will always be the primary payor.

E. Vision Care Benefits

1. How the Vision Care Benefit Works

Your vision benefit is administered by Davis Vision (the **vision administrator**), 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 the **vision administrator**. If you want frames and/or lenses that cost more than the Plan's limit, you will pay the difference. If you want contact lenses instead of frames and lenses, you will be responsible for paying for the contact lens fitting fee and the Plan will cover up to $120 towards the purchase of contact lenses.

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

2. Schedule of Covered Vision Services

Benefits	Participating Provider (In-Network)	Non-Participating Provider (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 the **vision administrator**.	Plan pays up to the **allowed amount** of $60.
Frames	Plan pays 100% if chosen from the Plan's selected collection with the **vision administrator**.	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.

Vision care benefits are payable within a 24-month consecutive period,* starting with the date you first incur a vision care expense (typically an eye exam). Unused vision care benefits cannot be carried over and used in a subsequent 24-month period. For example, if you get an eye exam on January 1, you have until December 31 of the following year to receive benefits for that period. The next 24-month period begins when you incur a new vision care expense, no earlier than 24 months after the previous period started.

For example, if you get an eye exam on September 1, 2024, you have up to September 1, 2026 (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.

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

You can access your Vision Plan benefits by:

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

To find a **participating provider**, visit the **vision administrator's** website or call them.

3. Eligible Expenses

The Plan covers the following vision care expenses:

- Eye examinations performed by a licensed ophthalmologist or optometrist,
- Prescribed corrective lenses you receive from a licensed and qualified optician, ophthalmologist or optometrist, and
- Frames.

4. Excluded Vision 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 health (hospital, medical, behavioral health and substance abuse) benefits described on pages 26–68),
- Non-prescription eyeglasses,
- Exam fitting fees for contact lenses,
- Adornment expenses,
- **Out-of-network** benefits for participants and dependent(s) under age 19, and
- Charges for services not rendered.

F. Fertility Benefits Through Progyny

1. How the Fertility Benefit Works

The Plan provides a fertility benefit **network** through Progyny. Progyny is a premier fertility **network** with benefits designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist you or your eligible spouse wishing to have a child. Progyny's program includes a credentialed **provider network** and a personalized concierge-style member support team, Patient Care Advocates (PCAs), who offer education, support, and coordinated care. You may contact Progyny toll-free at 1-866-960-3601. Your fertility benefits are described below.

Benefits are payable for covered medical expenses incurred by you and your eligible spouse for the diagnosis and treatment of fertility, subject to the Smart Cycle lifetime maximum described below. The person(s) receiving fertility treatment must be enrolled in the Plan to receive Plan-covered fertility benefits. You are responsible for **copays,** as described on the following page. Please contact Member Services to confirm your eligibility. Fertility benefits must be through the Progyny **network** (Progyny **in-network**) and must be pre-authorized by Progyny. No fertility benefits will be provided **out-of-network**. Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage.

Your benefit provides for one Smart Cycle and, if live birth is not achieved, one bonus Smart Cycle as your lifetime maximum. Smart Cycles are Progyny's benefit "currency" that is used to customize your lifetime benefit. Each Smart Cycle is designed to cover full treatment and bundles individual services, tests, and medications together so you will not exhaust your fertility treatment coverage mid-cycle. The Progyny Member Guide provides more information about your fertility treatment benefits. You can request the Progyny Member Guide by calling toll-free at 1-866-960-3601.

The following chart lists common fertility treatments, and states how much each treatment uses of a Smart Cycle. Progyny can provide more information about how the Smart Cycle benefit works.

Treatment Option	Smart Cycle Amount
IVF Fresh Cycle	3/4
IVF Freeze – All Cycle	3/4
Frozen Embryo Transfer (FET)	1/4
Frozen Oocyte Transfer (FOT)	1/2
Pre-Transfer Embryology Services	1/2
Intrauterine Insemination (IUI)	1/4
Timed Intercourse (TIC)	1/4
Egg Freezing	1/2
Sperm Freezing	1/4
Split Cycle (Egg & Embryo Freezing)	1/4
IVF Live Donor Fresh	1 and 1/2
IVF Live Donor Freeze-All	1
Purchase of 1 Cohort of Donor Eggs (6-8 eggs)	1
Purchase of Donor Sperm	1/4

The Progyny benefit also includes PGT-A (PGS, or pre-implantation genetic screening to assess embryo viability), PGT-M (PGD, or pre-implantation genetic diagnosis), pregnancy gap coverage until the Progyny **in-network** fertility clinic releases the patient into the care of an OBGYN medical **provider**, and transportation of your or your spouse's previously frozen reproductive tissue to **in-network facilities**.

Progyny Rx is the fertility medication **provider** and all medications prescribed as part of a Smart Cycle must be filled through Progyny Rx. You may not fill your fertility medications through OptumRx or any other pharmacy.

2. Types of Out-of-Pocket Costs for Fertility Benefits

The following **copays** apply to fertility services under the Progyny fertility benefit.

Benefit	In-Network	Out-of-Network	Limitations
Initial consultation and diagnostic testing bundle	Plan pays 100% after $40 **copay**.	No Coverage.	**Progyny in-network** only. Subject to lifetime maximum.
Treatment cycle	Plan pays 100% after $100 **copay**.	No Coverage.	**Progyny in-network** only. Subject to lifetime maximum.
Low-tech radiology services (e.g., hysterosalpingography)	Plan pays 100% – no **copay**.	No Coverage.	**Progyny in-network only**. Subject to lifetime maximum.
Prescriptions	$30 **copay** per fill.	No Coverage.	Must be filled with Progyny Rx. Covers pre-authorized fertility medications. Subject to lifetime maximum.

Below is an example of your estimated costs for one Smart Cycle. Your actual course of treatment may vary. Your Progyny **in-network** fertility **provider** will work with you to determine the best course of treatment for you.

Sample Treatment Type	Sample Copays	Sample Total Member Cost Share
IUI (1/4 Smart Cycle)	Initial consultation and diagnostic testing bundle – $40. Rx (assuming 2 prescriptions; $30 per prescription) – $60. IUI (treatment) - $100.	$200
IVF Fresh (3/4 Smart Cycle)	Rx (assuming 3 prescriptions; $30 per prescription) – $90. IVF (treatment) – $100.	$190

3. Exclusions

The following expenses are not covered under the Progyny fertility benefit:

- Fertility services for dependent children under age 26, except in cases of oncofertility or gender dysphoria.
- Domestic partners.
- Home ovulation prediction kits.
- Services and supplies furnished by an **out-of-network provider**.

- Services and supplies that are not listed as covered in the Progyny Member Guide. Please contact Progyny for more information.
- All charges associated with a gestational carrier program for the person acting as the carrier, including, but not limited to, fees for laboratory tests.
- Treatments considered **experimental** by the American Society of Reproductive Medicine, and
- Travel expenses.

If you are currently undergoing or seeking to begin fertility treatment, it is important that you contact Progyny toll-free at 1-866-960-3601 to speak to a Progyny Patient Care Advocate (PCA), who will help you understand your fertility treatment benefits. PCAs are available Monday through Friday from 9 am to 9 pm ET.

SECTION 3: ANCILLARY BENEFITS

A. Life Insurance Benefits

1. How Life Insurance Benefits Work

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.

2. Benefit Amount

The level of life insurance coverage depends on the Plan that you are covered under. If you are covered under the Basic Plan, your life insurance coverage is $10,000. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

For a copy of the life insurance 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.

3. When Life Insurance Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, except as provided on the following page or if you have Fund-paid Health Extension due to disability or arbitration. (See pages 13-15.) Life insurance coverage also ends if you cancel your coverage under this Plan due to Medicare eligibility or any other reason. (See below and pages 123-125.) 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.

4. Life Insurance Disability Extension

If you are disabled and receiving Short-Term Disability or Workers' Compensation benefits, your life insurance will continue for six months from the date of disability, or until your disability ends, whichever happens first. If you are eligible for either Long-Term Disability under the Metropolitan Plan or a Total Disability Benefit under the Building Service 32BJ Pension Fund, your life insurance will continue until the Plan terminates or is otherwise amended, your disability ends, or you reach age 65, whichever happens first. For as long as this extended coverage lasts, your benefit level will be frozen at the level in effect at the time you became disabled.

The Fund reserves the right to re-certify disability as described on pages 14-15. 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 111-120 for information on appealing a denied claim.)

B. Accidental Death & Dismemberment ("AD&D") Benefits

1. How AD&D Benefits Work

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.

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 $10,000 if you are covered under the Tri-State Plan. If you lose one hand at or above the wrist, or one foot at or above the ankle, or sight in one eye, the AD&D benefit payable is $5,000 if you are covered under the Tri-State Plan.

2. 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 or for any other reason or the Plan terminates or is otherwise amended. (See pages 12-15 and pages 123-124.) Like your life insurance, your AD&D coverage may continue for up to six months while you have Fund-paid Health Extension due to disability or arbitration. (See the previous page and pages 12-15.)

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

C. Short-Term Disability (STD) Benefits

1. How Short-Term Disability Benefits Work

Participants working in Connecticut under collective bargaining agreements that require a contribution rate that covers Short-Term Disability ("STD") benefits are covered by the Fund for STD benefits as described in this section. Please call Member Services at 1-800-551-3225 to determine your eligibility.

The STD benefit provides a weekly income to you if you become disabled while working in **covered employment**. This means that you are unable to perform the duties of your regular job because of a covered accident or sickness and are under the care of a legally recognized treatment **provider**.

Your STD benefits are administered by the Guardian Life Insurance Company of America. To file a claim for STD benefits contact Guardian TeleGuard at 1-888-262-5670, Monday through Friday, 8:00 am–8:00 pm.

Please note that this section serves only as an overview of the STD benefit program and is not a guarantee of payment or coverage. All claim determinations will require a full review by the Guardian Life Insurance Company of America and will be subject to the terms and conditions set forth in the actual plan of insurance.

2. Eligibility

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

- You must be considered disabled as defined by the STD plan,
- You are under the direct regular care of a non-related legally recognized treatment **provider**, and
- Your disability is not the result of a job-related or on-the-job injury or illness.

3. When Benefits End

Benefits end when any of the following events occur:

- You are no longer disabled,
- You are able to perform the major duties of your own job with reasonable accommodation, regardless of whether you return to your job,
- You return to gainful employment,
- You fail to provide proof of loss as required by the **benefit administrator**,
- You no longer receive regular and appropriate care for the condition you are claiming disability for, or
- You have received the maximum number of weeks of STD.

4. Benefit Limitations and Exclusions

The following limitations and exclusions apply to this benefit:

- Your disability will not begin until you have visited a legally recognized treatment **provider** for the illness or injury that caused the disability.
- Each length of the disability due to the same or a related illness will be treated as a recurring disability if said disability recurs within 30 days after you were last entitled to benefits, provided all STD benefit plan provisions are met.
- Two periods of disability due to the same or a related illness will be treated as a recurring disability if said disability recurs within 30 days after you were last entitled to benefits, provided all STD benefit plan provisions are met.
- Benefits will only be paid during periods when loss of wages occurs, and
- Gross weekly benefits may be reduced if you are receiving retirement benefits under the Unites States Social Security Act, as well as other sources of income listed in the STD plan.

5. Filing a Claim for STD Benefits

To file a claim for STD benefits contact Guardian TeleGuard at 1-888-262-5670, Monday through Friday 8:00 am–8:00 pm. If you file a

claim for STD benefits, Guardian will make a decision on the claim and notify you directly.

6. Appealing a Denied Claim for STD Benefits

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

D. Death Benefit for Pensioners

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

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

If you do not name a beneficiary, your beneficiary dies before you and you have not named a new beneficiary, or you do not have a beneficiary recorded in the Fund's electronic recordkeeping system, your pensioner death benefit will be payable in the following order: 1) your spouse, if living, 2) your living children, equally, 3) your living parents, equally, and 4) if none of the above, your estate.

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

SECTION 4: GETTING YOUR BENEFITS

A. 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.

1. Filing 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 **PBM 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 Health (Hospital, Medical, Behavioral Health and Substance Abuse) Claims

If you use an **in-network provider**, and provide your ID card to the **provider** at the time of service, you do not have to file claims. The **provider** will do it for you. If you do not provide your ID 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 health (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 105 for information on where

to file your claim for benefits received **out-of-network.** ***Claims filed more than 180 days after the date of service will be denied***.

- Complete all information requested on the form.
- Attach original bills or receipts.
- If you have other coverage and this Plan 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 121-125.)
- Keep a copy of your claim form and all attachments for your records.

Filing Pharmacy Claims

If you use your prescription benefit card at a **participating pharmacy** or if you have your prescription delivered to you from 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 forget your card and pay cash, then you must file a claim for benefits. Refer to the table on page 105 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 the prescription is filled will be denied.***

Filing Dental Claims

When you see a dental **network participating provider**, the **provider** will file all claims for you directly with Delta Dental, the administrator for the Plan's dental coverage. Delta Dental will pay the **participating provider** 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 the **dental administrator's** web site at www.deltadentalins.com/32bj or calling 1-800-589-4627. Refer to the table on page 105 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 the **dental administrator** 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 the dental administrator within 180 days after the date of service. Claims received more than 180 days after the date of service will be denied.***
- Payment for all services received from a **non-participating 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 a service not reasonably necessary, or not customarily performed, for the maintenance of the patient's health.

Filing Vision Claims

If you use a **participating vision provider**, you do not have to file claims. The **provider** will do it for you. If you do not use a **participating vision provider**, then you must file a vision claim with Davis Vision, the **vision administrator**, for reimbursement of eligible expenses. Refer to the table on page 105 for information on where to file your claim for benefits received **out-of-network**. You can obtain a vision claim form from www.davisvision.com/32bj or call 1-800-603-5633. ***Vision claims should be filed as soon as possible, but never later than 180 days after the date of service. Claims filed more than 180 days after the date of service will be denied.***

Filing Fertility Claims

If you use Progyny **in-network** fertility **providers**, you do not have to file claims. The **providers** will do it for you and work with your Patient Care Advocate at Progyny. There is no **out-of-network** coverage for fertility care.

Filing for a Pensioner's Death Benefit

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

Filing Life Insurance and AD&D Claims

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

Where to Send Claim Forms

Benefit	Filing Address
Health (Hospital, Medical, Behavioral Health and Substance Abuse) (**out-of-network** only; no claim forms are necessary for **in-network care**)	Anthem 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 (claims only need to be filed when prescription ID card was not presented at a pharmacy and full price was paid; 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
Death Benefit for Pensioners	Building Service 32BJ Benefit Funds 25 West 18th Street New York, NY 10011-4676 Attn: Retirement Services
Life Insurance Accidental Death & Dismemberment	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100

Approval and Denial of Claims

There are separate claims denial and approval processes for health services claims (hospital, medical, behavioral health and substance abuse), ancillary health services claims (pharmacy, dental and vision), pensioner's death benefit claims, and life/AD&D Claims. These processes are described separately on the following pages. Please review this information to ensure that you are fully aware of these processes and what you, or your authorized representative, need to do in order to comply.

Designating an Authorized Representative

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

- Your name,
- Your identification number as shown on your ID cards from your **PBM, ("Pharmacy Benefits Manager") claims, dental** and **vision administrators,** 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 that clearly states that the party is authorized to file a claim and/or an appeal on your behalf.

An Authorization to Release Health Information Form can be found on our website at www.32bjfunds.org or you can call Member Services to have one mailed to you.

2. Time Frames for Deciding Claims

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

- *Health Services (hospital, medical, behavioral health and substance abuse) claims:* Prior approval (also called "pre-authorization") is required for some health services benefits (see pages 39-41).
- *Pharmacy claims:* Certain medications on the Plan's formulary require Prior Authorization before your prescription will be covered under the Plan (see pages 72-73). Please note you may have to pay the entire cost of the prescription if you do not get prior approval before filling a prescription; these claims will not be reimbursed.
- *Dental and Vision claims:* There are no pre-service claims for dental or vision claims under the Plan.
- *Fertility claims:* Prior approval is required for fertility benefits (see pages 93-96, and page 104,).

Type of Request for Benefits	Timing
Properly Filed Pre-Service Claims	
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.
Improperly Filed Pre-Service Claims	
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, current address, the specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
Unless the claim is refiled properly, it will not constitute a claim. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your **provider**:	*will have 45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.

Type of Request for Benefits	Timing
Improperly Filed Pre-Service Claims (continued)	
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 Request for Benefits

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 **provider** 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 **provider** with knowledge of your medical condition determines is an urgent care claim will automatically be treated as such.

You do not need to submit urgent care appeals in writing. You should call the claims reviewer as soon as possible to appeal an urgent care request for benefits. A **health care provider** 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 106 for details.

Type of Request for Benefits	Timing
Properly Filed Urgent Care Claims	
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.
Improperly Filed Urgent Care Claims	
If you do not follow the Plan's procedures for filing an urgent care claim, you will be notified:	*within 24 hours* of the failure and the proper procedures to follow. This notification may be oral, unless you request written notification. You will only receive notification of a procedural failure if your claim includes your name, your specific medical condition or symptom, and a specific service, treatment or product for which approval is requested.

Type of Request for Benefits	Timing
Incomplete Urgent Care Claims	
If your request for benefits is incomplete (e.g., you did not give enough information for the claims reviewed 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.

Concurrent 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.

Type of Request for Benefit	Timing
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 matters beyond the control of the Plan.
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.

Type of Request for Benefit	Timing
If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case:	*you will have 45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.
During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice:	*either for 45 days or until the date the claims reviewer receives your response* to the request (whichever is earlier). Within *15 days* after the expiration of this time period, you will be notified of the decision

Pensioners Death Benefit Claims

If your beneficiary files a claim for death benefits, the Fund will make a decision on the claim and notify your beneficiary *within 90 days* of receipt of the claim. If the Fund requires an extension of time due to matters beyond its control, the Fund is permitted an additional *90 days*. The Fund will notify your beneficiary prior to the expiration of the original 90-day period of the reason for the delay and when the decision will be made. A decision will be made within the 90-day extension period, and your beneficiary will be notified in writing by the Fund.

Life and AD&D Claims

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

3. 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 Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") no more than three years after the date an appeal is 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 106-110.

4. Appealing Denied Claims

An appeal is a request by you (or your authorized representative) to have an adverse benefit determination (a denied claim) 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 denied Life/AD&D Claims, contact MetLife.

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

An administrative health services, pharmacy or fertility claim is one that 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.

Type of Denied Claim	Level-One Appeal	Level-Two Appeal
Health Services Claims (**Medical Judgment**)	Anthem BlueCross BlueShield	Independent Review Organization ("IRO")
Health Services Claims (Administrative)	Anthem BlueCross BlueShield	Board of Trustees (This level of appeal is voluntary)
Ancillary Health Services Claims:		
• Pharmacy (**Medical Judgment**)	OptumRx	Independent Review Organization ("IRO")
• Pharmacy (Administrative)	OptumRx	Board of Trustees*
• Dental (**Medical Judgment** and Administrative)	Delta Dental	Board of Trustees*

Type of Denied Claim	Level-One Appeal	Level-Two Appeal
Ancillary Health Services Claims: (continued)		
• Vision (**Medical Judgment** and Administrative)	Davis Vision	Board of Trustees*
Fertility (Medical Judgment)	Progyny	Independent Review Organization ("IRO")
Fertility (Administrative)	Progyny	Board of Trustees*
Life/AD&D	MetLife Insurance Company	Not applicable
Pensioner's Death Benefit	Board of Trustees	Not applicable

* This level of appeal is voluntary.

Filing an Appeal

For health services claims (hospital, medical, behavioral health and substance abuse), prescription drug claims, fertility claims, dental, and vision claims, you have *180 days* from the date of the original claim denial notification letter to file a level-one appeal.

For pharmacy claims requiring a prior authorization that has been denied, you have *180 days* from the date of the original denial notification letter to file a level-one appeal.

For life, AD&D, and pensioner's death claims, you have *180 days* from the date of the original denial 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 claims reviewer's administrative processes for ensuring consistent decision-making.
- It constitutes a statement of Plan policy regarding the denied treatment or service.

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

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

Where to File a Level-One Appeal

Benefit	Write to:	Or Call
Health (Hospital, Medical Behavioral Health Substance Abuse)	Anthem BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407 or file online by logging into Anthem.com	1-866-316-3394 If an appeal is urgent, you should request an expedited appeal.
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. An appeal of an urgent clinical claim also may be filed by calling OptumRx Customer Care.
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. An appeal of an urgent care dental claim also may be filed by calling Delta Dental at 1-800-589-4627.
Fertility (Medical Judgment)	appeals@npua.com	1-866-960-3596
Fertility (Administrative)	Email your dedicated Patient Care Advocate.	1-866-960-3601

Benefit	Write to:	Or Call
Death Benefit for Pensioners	Board of Trustees' Appeals Committee c/o Building Service 32BJ Pension Fund 25 West 18th Street New York, NY 10011-4676 You may appear in person at the Appeals Committee meeting, but you are not required to be there. If you do not attend, the Appeals Committee will decide your appeal based on all of the materials you have submitted in writing.	Appeals are only accepted in writing.
Life Insurance Accidental Death & Dismemberment	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 1-570-558-8645	Appeals are only accepted in writing.

5. Time Frames for Decisions on Appeals

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

Expedited Appeals for Urgent Care Claims	
Description of Appeal Process	**Timing**
If your claim involves urgent care for health services (hospital, medical, behavioral health and substance abuse) or prescription drugs , 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. An urgent care 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 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), Ancillary Health Services, or Fertility Claim Appeal	
Description of Appeal Process	**Timing**
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 concurrent care claim (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 or Concurrent Care Health Services (Hospital, Medical, Behavioral Health and Substance Abuse), Ancillary Health Services, or Fertility Claim Appeal	
Description of Appeal Process	Timing
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.

6. External Appeal for Claims Involving Medical Judgment

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

If you are not fully satisfied with the **claims administrator's** decision on an internal appeal of a claim that involved **medical judgment**, you may request that your appeal be sent to an Independent Review Organization ("IRO") for review. The IRO is composed of persons who are not employed by the **claims administrator** or any of its affiliates. A decision to request an appeal to an IRO will not affect your rights to any other benefits under the Plan.

There is no charge for this independent review process. The Plan will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a **medical judgment** or clinical-appropriateness determination by the **claims administrator**. 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 the **claims administrator** (information can be found in the Contact Information section at the back of this document) *within four months* of the date of **claims administrator's** internal appeal denial letter. The **claims administrator** will then forward the file to the IRO. Upon receiving your information, the IRO will notify you whether your request is eligible and accepted for an external review. Once you receive this letter, you have 10 business days to submit (in writing) additional information for the IRO to consider in its review. 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 the **claims administrator'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 the **pharmacy benefit manager's** level-one appeal review of a claim that involved **medical judgment**, you may request that they send your appeal to an IRO for review.

The IRO is composed of persons who are not employed by the **pharmacy benefit manager**, or any of its affiliates. A decision to request an appeal to an IRO will not affect your rights to any other benefits under the Plan.

There is no charge for this independent review process. The Plan will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a **medical judgment** or clinical-appropriateness determination by the **pharmacy benefit manager**. 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 the **pharmacy benefit manager** *within four months* of the date of their level-one appeal review denial letter. The

pharmacy benefit manager 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 the **pharmacy benefit manager's** independent medical specialist, the Independent Review Organization ("IRO") review shall be completed *within 72 hours*.

Fertility Claims

If you are not fully satisfied with Progyny's level-one appeal decision of a claim that involved **medical judgment**, you may request that your appeal be sent to an Independent Review Organization ("IRO") for review. The IRO is composed of persons who are not employed by Progyny or any of its affiliates. A decision to request an appeal to an IRO will not affect your rights to any other benefits under the Plan. There is no charge for this independent review process. The Plan will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a **medical judgment** or clinical appropriateness determination by Progyny.

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 Progyny *within four months* of the date of Progyny's level-one appeal denial letter. Progyny will then forward the file to the IRO. The IRO will provide written notice of its decision *within 45 days*.

7. Voluntary Level of Appeal for Administrative Health Claims, Pharmacy Claims, or Fertility Claims, and Level-One Appeal of Dental or Vision Claims

Once you have received notice of the denial of your timely* internal appeal of an administrative health claim, pharmacy claim, or fertility claim, or a level-one appeal of a dental or vision claim, you have exhausted all required

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

internal appeal options and may file a voluntary level of appeal. Please note: there are no expedited appeals for post-service claims or for health, pharmacy or fertility claims that involve **medical judgment** under the voluntary appeal procedure.

If you disagree with the initial internal appeal decision, you are free to file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. You may not start a lawsuit to obtain benefits until you have completed the mandatory appeals process and a final decision has been reached, or until the appropriate time frame described in this SPD has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. ***In addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied.*** Alternatively, you may file a voluntary appeal with the Appeals Committee of the Board of Trustees by following the procedures outlined in this section.

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 114. Voluntary appeals are heard at regularly scheduled meetings of the Appeals Committee. However, if your request is received less than 30 days before the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension is necessary.

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 authorized representative) with sufficient information to decide whether to submit a claim through the voluntary appeal process, including your right to representation.

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

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

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

Appeal Decision Notice

Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than *five days* after the decision has been reached. The appeal decision notice will include all of the information set forth under the section Notice of Decision on pages 110-111.

8. Pensioner Death Benefit Claim Appeal

If you file an appeal of a pensioner death benefit claim, a decision will be made at the next regularly scheduled meeting of the Appeals Committee following receipt of your appeal. However, if your request is received less than 30 days before the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension is necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than *five days* after the decision has been reached. The appeal decision notice will include all of the information set forth under the section Notice of Decision on pages 110-111.

9. Further Action

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

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

If you have any questions about the appeals process, please contact the Compliance Office at the address on page 145. 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.

B. Incompetence

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

C. No Duplication of Health Coverage

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

D. 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 to 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.

E. Coordination of Benefits*

1. Introduction

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

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

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

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* There are separate coordination of benefits rules applicable to dental benefits, which can be found on pages 89-90.

2. Other Health Plans

Except for the situations such as Medicare and **TRICARE**, as described on pages 123-124, and for dental benefits, as described on pages 89-90, the rules for determining which plan is primary are as follows:

- If the other plan does not have a COB provision with regard to the particular expense, that plan is always primary.
- The plan that covers the patient as an active employee is primary and the plan that covers the patient as a dependent is secondary.
- If the patient is covered both as an active employee (or as a dependent of an active employee) and as either a laid-off employee or a retired employee, then the active employee's plan will be primary. However, if the other plan does not have this rule and the two plans do not agree as to which coverage is primary, then this rule will not apply.
- If the patient is a dependent child of parents who are not separated or divorced, then the plan covering the parent whose birthday (month and day, not year of birth) falls earlier in the calendar year is primary and pays first. If both parents have the same birthday, the plan covering either parent the longest is primary. If the other plan does not use this "birthday rule," then that plan is primary, unless the primary plan is already determined under the above rules.
- If the parents of a dependent child are legally divorced or separated (and there is no court decree establishing financial responsibility for the child's health care expenses), the plan covering the parent with custody is primary. If the parent with custody is remarried, that parent's 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**.

3. Medicare

If you are covered by this Plan and Medicare, the following rules apply

- 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 they reach 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 to get back into this Plan. Additionally, if you cancel your coverage under this Plan, the Plan will not be allowed to offer you any benefits that would supplement Medicare's benefits. When you cancel coverage under this Plan, all benefit coverage is cancelled, including medical, hospital, behavioral health and substance abuse, prescription drug, dental, vision, Life Insurance and Accidental Death & Dismemberment, pensioner death benefit, and Short-Term Disability.

- If you are not in **covered employment** (for example, you are an early or disability retiree or you are receiving LTD ("Long-Term 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 in Medicare Part A and Part B coverage, because this Plan pays as secondary, you will be financially responsible for what Medicare would have paid if your dependent(s) had enrolled Medicare Part A and Part B coverage. Those covered family members who are not eligible

for Medicare continue to receive primary coverage from this Plan. This Plan pays primary for the first six months of Short-Term Disability and Workers' Compensation. However, Medicare may require enrollment within three months after you turn 65.

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

4. TRICARE

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

5. 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 their health care benefits under the no-fault coverage will the claimant 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.

6. 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.

7. 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 126-129).

F. 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 a member's plan.

G. Subrogation and Reimbursement

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

If you, or your dependent(s), are injured as a result of negligence or other wrongful acts, whether caused by you, your dependent(s) or by another party, and you, or your dependent(s), apply to this Fund for benefits and receive such benefits, this Fund shall then have a first-priority lien for the full amount of those benefits should you recover any monies from any party that caused, contributed to or aggravated the injuries or from any other source otherwise responsible for payment thereof. This first-priority lien applies whether these monies come directly from your own insurance company,

another person or their insurance company, or any other source (including, but not limited to, any person, corporation, entity, uninsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage or no-fault automobile coverage, or any other insurance policy or plan).

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

Any and all amounts received from any party or any other source by judgment, settlement or otherwise, must be applied first to satisfy your reimbursement obligation to the Fund for the amount of medical expenses paid on your behalf or on your dependent's behalf. The Fund's lien is a lien of first priority for the entire recovery of funds paid on your behalf.

Where the recovery from another party or any other source is partial or incomplete, the Fund's right to reimbursement takes priority over your, or your dependent's, right of recovery, regardless of whether or not you, or your dependent, have been made whole for the injuries or losses. The Fund does not recognize, and is not bound by, any application of the "make whole" doctrine.

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

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

- To restore to the Fund the full amount of the benefits that are paid to you, and/or your dependent(s), from the proceeds of any payment, compromise, settlement, judgment and/or verdict, to the extent permitted by law,
- That the proceeds of any compromise, settlement, judgment and/or verdict received from another party, an insurance carrier or any other source, if paid directly to you (or to any other person or entity) will be held by you (or such other person or entity) in a constructive trust for the Fund. (The same rules apply to any other person to whom you assign your rights.) The recipient of such proceeds is a fiduciary of the Fund with respect to such funds and is subject to the fiduciary provisions and

obligations of ERISA. The Fund reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Fund's subrogation or reimbursement rights,

- That any lien the Fund may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in an action to recover from another party or any other source, and these expenses may not be used to offset your obligation to restore the full amount of the lien to the Fund, and
- That any recovery will not be reduced by, and is not subject to, the application of the common fund doctrine for the recovery of attorney's fees.

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

Should you seek to recover any monies from another party or any other source that caused, contributed to, aggravated your injuries or is otherwise responsible, it is a rule of this Plan that you must give notice in writing of same to the Fund within ten days after either you, or your attorney, first attempt to recover such monies, or institute a lawsuit, or enter into settlement negotiations or take any other similar action. You must also cooperate with the Fund's reasonable requests concerning the Fund's subrogation and reimbursement rights and keep the Fund informed of any important developments in your action. You must also provide the Fund with any information or documents, upon request, that pertain to, or are relevant to, your actions. If litigation is commenced, you are required to give at least five

days' written notice to the Fund prior to any action to be taken as part of such litigation including, but not limited to, any pretrial conferences or other court dates. Representatives of the Fund reserve the right to attend such pretrial conferences or other court proceedings.

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

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

Carelon Subrogation
P.O. Box 659940
San Antonio, TX 78265

H. 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.

I. Continued Group Health Coverage

1. During a Family and Medical Leave

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

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

2. During Military Leave

If you are on leave for active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you and your dependent(s), at your own expense, for up to 24 months, provided you enroll for coverage.

This continuation coverage operates in the same way as COBRA. (See pages 13-15 and pages 131-136 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 124.)

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.
- 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.

3. Under COBRA

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

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

If you are disabled and receiving (or are approved to receive) benefits under Short-Term Disability or Workers' Compensation, the Plan provides Fund-paid Health Extension for disability coverage for up to six months from your last day worked, as long as you remain disabled, are unable to work and you apply for coverage.

If you are terminated by your **employer** and your termination is going to arbitration seeking reinstatement, the Plan provides coverage for up to six months from your date of termination. In these two cases, you do not have to pay the premium since it is paid by the Fund. Keep in mind that the maximum period that you have COBRA coverage is reduced by any period of time you receive Fund-paid Health Extension coverage.

The table below 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 In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months). See *Multiple Qualifying Events* on the next page for details.
You, and your eligible dependent(s)	You become ineligible for coverage due to a reduction in your employment hours (e.g., leave of absence).	
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.

* This is a continuation requirement of USERRA not COBRA and different rules may apply. Contact Member Services with any questions.

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, or during any open enrollment period that may apply.

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

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

The two periods combined cannot exceed a total of 36 months from the date of your termination (the first Qualifying Event). A second Qualifying Event may also occur for your dependents if you become legally separated, get legally divorced or your marriage is civilly annulled, or you 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 of 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, including civil annulment, 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:

- Date of the Qualifying Event and
- Type of Qualifying Event. (See the table of Qualifying Events on page 132.)

*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, or your eligible dependents, 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, or during an open enrollment period if applicable. 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, or during an open enrollment period if applicable.

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

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

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

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

What COBRA coverage provides. COBRA generally offers the same health coverage that is made available to similarly situated employees or family members; however, Life/AD&D and long-term disability (Metropolitan Plan only) are not available, except as provided under Fund-paid Health Extension for up to six months. If, during the period of COBRA continuation coverage, the Plan's health benefits change for active employees, the same changes will apply to COBRA recipients.

When COBRA coverage ends. COBRA coverage ordinarily ends after the maximum coverage period shown in the table on page 132. 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 payment 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 or
- 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 before the end of the original period, you will be notified.

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

SECTION 5: GENERAL INFORMATION

A. Other Health Plan Information You Should Know

1. Assignment of Plan Benefits

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

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

Although as described previously, 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 106.

2. 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 Member Services at the address on the inside back cover of this document.

3. 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**.

4. 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 145.

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 145.

5. 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 health (hospital, medical, behavioral health and substance abuse), prescription drug, dental, vision, STD or AD&D benefits to individual coverage.

B. General Information

1. Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between the Realty Advisory Board on Labor Relations, Inc., or other **employers** and your union. These collective bargaining agreements

provide that **employers** contribute to the Fund on behalf of each covered employee. **Employers** that are parties to such collective bargaining agreements may also participate in the Fund on behalf of non-collectively bargained employees, if approved by the Trustees, by signing a participation agreement. Certain other **employers** (such as Local 32BJ itself, the 32BJ Benefit Funds and the Realty Advisory Board) participate in the Fund on behalf of their employees by signing a participation agreement.

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

2. 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. Except as otherwise noted, 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. The **dental administrator** will escheat uncashed checks for dental benefits to the state after the legally required time has passed. You may be able to recover any uncashed checks for dental benefits that were escheated to the state from the state. Contact the **dental administrator** if you have questions about uncashed dental benefit checks.

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 13-15 and pages 131-136).

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 126-129 and Overpayments on page 129.)

3. Compliance with Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current federal law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law takes precedence over state law. To the extent that state law applies, the Plan will be construed under the laws of the State of New York.

4. 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.

5. Plan Administration

The Plan is what the law calls a "health and welfare" benefits program. Benefits are provided from the Fund's assets. Those assets are accumulated

under the provisions of the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to covered participants and dependent(s) and defraying reasonable administrative expenses.

The Plan is administered by the Board of Trustees, except those portions provided by insurers in fully insured arrangements. The Board governs this Plan in accordance with an Agreement and Declaration of Trust. The Board, and/or its duly authorized designee(s), has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan established under the Trust Agreement, and to decide all matters arising in connection with the operation or administration of the Plan established under the Trust. Without limiting the generality of the foregoing, the Board, and/or its duly authorized designee(s), including the Appeals Committee with regard to benefit claim appeals, shall have the sole and absolute discretionary authority to:

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

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

The Board has delegated certain administrative and operational functions to the Fund staff, other organizations and to the Appeals Committee. Most of your day-to-day questions can be answered by Member Services. If you wish to contact the Board, please write to:

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

6. 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 13-15 and pages 131-136 for information about COBRA), and the documents governing the Plan on the rules governing your COBRA continuation rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your **employer**, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's appeal process. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in federal court. You may not file a lawsuit until you have followed the appeal procedures described on pages 102-119. 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 the 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.

C. Plan Facts

This SPD is the formal plan document for the Tri-State Plan of the Health Fund.

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

1. Funding of Benefits and Type of Administration

Self-funded, except MetLife insures the Life and AD&D insurance benefits and Guardian Life Insurance Company of America insures the Short-Term Disability benefits.

Contributions to the Trust Fund are made by **contributing employers** under the Plan, in accordance with their written agreements, and by COBRA qualified beneficiaries. Benefits are administered by the organizations listed in the table on page 113.

2. Plan Sponsor and Administrator

The Plan is administered by a joint Board of Trustees consisting of union Trustees and **employer** Trustees. The Board may be contacted at:

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

3. Participating Employers

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

To contact the Compliance Office, write to:

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

To contact the Health Fund, call:

1-800-551-3225

or write to:

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

4. Agent for Service of Legal Process

The Board has been designated as the agent for the service of legal process. Legal process may be served at the Compliance Office or on the individual Trustees. For disputes arising under the portion of the Plan insured by MetLife, service of legal process may be made upon MetLife, Customer Relations, 500 Schoolhouse Road, Johnstown, PA 15904 or upon the supervisory official of the Insurance Department of the state in which you reside. For disputes arising under the portion of the Plan insured by Guardian, legal process may be served at the 10 Hudson Yards, Corporate Compliance: Complaints Dept., New York, NY 10001.

D. Glossary

Allowed amount means the maximum amount that the Fund will pay for a covered service. When you go **in-network**, the **allowed amount** is the amount the **claims administrator** and the **in-network provider** have contractually agreed upon.

When you go **out-of-network**, the **allowed amount** is the amount paid for a medical service in a geographic area based on the average county rate for facilities and the **in-network** PPO rate for **health care providers**.

Claims administrator is Anthem Blue Cross Blue Shield. Anthem is the third-party administrator the Board of Trustees has contracted with to process health (hospital, medical, behavioral health and substance abuse) claims as well as administer the medical and **hospital network**. Anthem administers the **network** for participants who reside within the New York, New Jersey and Connecticut services area which is referred to as the Blue Cross Blue Shield Direct Point-of-Service ("POS") **network**. Anthem also administers the **network** for those participants who reside outside the New York, New Jersey and Connecticut services area which is referred to as the Preferred Provider Organization ("PPO") **network**.

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 Fund, and the agreement requires contributions to the Fund for work in **covered employment**.

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

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

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

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

Dental administrator is Delta Dental. Delta Dental is the third-party administrator the Board of Trustees has contracted with to process dental claims as well as administer the dental **network**.

Durable medical equipment and **prosthetics** is equipment and **prosthetics** that are:

- Designed and intended for repeated use,
- Primarily and customarily used to serve a medical purpose,
- Generally not useful to a person in the absence of disease or injury,
- Appropriate for use in the home, and
- Ordered and/or prescribed by a **health care provider**.

Non-durable medical equipment and supplies means supplies that:

- Are usually disposable in nature or have a very limited useful lifetime,
- Cannot withstand repeated use,
- Primarily and customarily serve a medical purpose,
- Generally, are not useful to a person in the absence of illness or injury, or
- Are ordered and/or prescribed a **health care provider**.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that would place the health of the individual (or, with respect to a pregnant person, the health of the person or their unborn child):

- In serious jeopardy, or
- Result in serious impairment to bodily functions, or
- Result in serious dysfunction of any bodily organ or part.

Emergency Services means any of the following, with respect to an **Emergency**:

- An appropriate medical screening examination that is within the capability of the **emergency** department of a **hospital**, including ancillary services (anesthesiology, pathology, radiology, and neonatology) routinely available in the **emergency** department to evaluate the **emergency** condition.
- Further medical examination and treatment as are required to stabilize the patient (regardless of the department of the **hospital** in which such further examination or treatment is furnished), or
- Post-stabilization services following an **emergency** to the extent required by applicable law.

Employer (see **Contributing employer**).

Experimental or *investigative* means treatment that, for the particular diagnosis or treatment of the patient'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. The **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 least improves health outcomes in standard medical practice or that it can be used in appropriate medical situations where the established treatment cannot be used.

Facility: A **hospital**; outpatient, **ambulatory or same-day surgery facility**; birthing center; dialysis center; rehabilitation **facility**; **skilled nursing facility**; hospice; home health agency or home care services agency that is licensed and operated according to the applicable state law in which the **facility** is located.

For behavioral health services, including room and board charges, the definition includes **facilities** that are licensed and operated according to the applicable state law in which the **facility** operates to diagnose and treat mental health or substance abuse disorders and includes inpatient and residential care, partial hospitalization and intensive **outpatient** programs, and comprehensive care centers for eating disorders. **Out-of-network** New York substance abuse facilities must be certified and/or licensed by the Office of Alcoholism and Substance Abuse Services.

All **out-of-network facilities** in all other states must be certified by a similar state agency and accredited by The Joint Commission. Coverage for partial hospitalization, intensive **outpatient** and residential treatment **facilities** and comprehensive care centers for eating disorders, including room and board charges, is limited to the diagnosis and treatment of behavioral health (mental health and substance use) disorders.

Physical therapy is covered **in-network** only at **hospitals** or **facilities** within the **network**. In such case, the definition of **facility** includes a **facility** that has an operating certificate issued by the New York State Department of Health to provide physical therapy services, and participates with the POS or PPO **network** if services are received outside of the Anthem New York service area. In other states, the **facility**

must have an operating certificate issued by the state using criteria similar to New York's.

Kidney dialysis treatment is covered **in-networ**k only at **hospitals** or **facilities** within the **network**. In such case, the definition of **facility** includes a **facility** that has an operating certificate issued by the New York State Department of Health to provide dialysis services, and participates with the POS or PPO **network** if services are received outside of the Anthem New York service area. In other states, the **facility** must have an operating certificate issued by the state using criteria similar to New York's.

For pregnancy and childbirth services, the definition of **facility** includes any birthing center that is **in-network** with the POS or PPO **network** if services are received outside of the Anthem New York service area.

Fertility administrator is Progyny. Progyny is the third-party administrator the Board of Trustees has contracted with to process fertility claims as well as administer the fertility **network**. Progyny **in-network providers** and suppliers are those who have contracted with Progyny to provide fertility services, supplies, and prescription drugs at a pre-negotiated rate.

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**.

Health care provider or **provider** means an appropriately licensed, registered or certified and qualified **provider** (e.g., M.D., D.O., D.C. or D.P.M., nurse practitioner, chiropractor, midwife, etc.) 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 their license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

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.

Hospital: A short term, acute, general **hospital**, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons.
- Has organized departments of medicine and major surgery; has a requirement that every patient must be under the care of a physician or dentist.
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.).
- If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k).
- Is duly licensed by the agency responsible for licensing such **hospitals**, and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

In-network (or **participating**) **providers** and suppliers are those who have contracted with the Fund, the **claims administrator**, the **prescription drug administrator**, the **dental administrator**, the **vision administrator**, the **fertility administrator**, or with any other administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services provided must fall within the scope of their individual professional licenses.

Medical Judgment means the opinions or determinations of a **health care provider** that directly affect the allocation of health care resources in the diagnosis, treatment and/or management of a patient's medical condition. **Medical judgment** is developed through practice, experience, knowledge and continuous critical analysis and is used to guide **providers** in sound decision making.

Medically necessary or **medical necessity**, as determined by the **claims administrator, pharmacy benefit manager, dental administrator, the vision administrator, fertility administrator**, or the Fund, means services, supplies or equipment that satisfy all of the following criteria:

- Are provided by a **health care provider**, **hospita**l 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 the applicable **administrator's** 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 an **in-network or out-of-network health care provider** may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it **medically necessary**.

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

Non-Preferred in-network hospitals and facilities (**non-preferred hospitals** and **facilities**) are those **in-network facilities** and **hospitals** that are not designated by the **claims administrator** as **preferred facilities** and **hospitals**. **Non-preferred hospitals** and **facilities** have higher **copays** and costs are higher than **preferred hospitals** and **facilities**.

Out-of-network (**non-participating**) **provider**/supplier means a **health care provider, pharmacy, dentist** or other professional **provider** or **durable medical equipment**, **home health care** or home infusion supplier who is not in the Plan's **network** for health services (hospital, medical, behavioral health and substance abuse), prescription drug, vision or dental services, or fertility services. **Out-of-network** *benefits* are benefits for **covered services** provided by **out-of-network providers** and suppliers when benefits provided by **out-of-network or non-participating providers** are covered under the Plan. **Out-of-network** New York **outpatient** substance abuse **providers** must be certified and/or licensed by the Office of Alcoholism and Substance Abuse Services. **Out-of-network providers** in all other states must be certified by a similar state agency and accredited by The Joint Commission.

Outpatient, ambulatory or same-day surgery (including invasive diagnostic procedures) means surgery that does not require an overnight stay in a **hospital** or **facility** and:

- Is performed in an **outpatient**, **ambulatory** or **same-day facility** or **hospital**, which is licensed by the appropriate state regulatory agency to provide surgical and related medical services on an **outpatient** basis.
- Requires the use of both surgical operating and postoperative recovery rooms.
- Does not require an inpatient admission, and
- Would justify an inpatient admission in the absence of an **outpatient** program.

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**.

Participating pharmacies are those pharmacies that have contracted with the **prescription drug administrator** to provide prescription medications at a pre-negotiated rate.

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

Participating vision providers are those who have contracted with the **vision administrator** to provide vision services at a pre-negotiated rate.

Pharmacy benefit manager (PBM) is OptumRx. OptumRx is the third-party administrator the Board of Trustees has contracted with to process prescription drug claims as well as manage the pharmacy **network**, including OptumRx Home Delivery (referred to as the Mail Order Program or Pharmacy) and the Optum® Specialty Pharmacy (referred to as the Specialty Pharmacy).

Preferred in-network hospitals and facilities (**Preferred hospitals and facilities**) are those **in-network facilities** and **hospitals** that are designated by the **claims administrator** as **preferred facilities** and **hospitals**. **Preferred hospitals and facilities** have the lowest **copays** and costs.

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.

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.

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

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

Manny Pastreich, *Chairman*
Howard I. Rothschild, *Secretary*
Peter Goldberger, *Executive Director*
Cora Opsahl, *Fund Director*

Summary of Material Modifications
Building Service 32BJ Health Fund Tri-State Plan

The following is a list of changes and clarifications that have occurred since the printing of the Building Service 32BJ Health Fund Summary Plan Description (SPD) for the Tri-State Plan dated June 1, 2024. This Summary of Material Modifications (SMM) supplements or modifies the information presented in your SPD with respect to the Plan. **Please keep this document with your copy of the SPD for future reference.**

Change in contact information, inside of the back cover of the booklet, after page 156: The header, "Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits" within the "Contact Information" table is replaced with the below:

Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits		
• To find a 5 Star Center • To find a primary care physician • To find an in-network provider	Member Services	Call 1-800-551-3225 8:30 a.m. –5:00 p.m., Monday–Friday, or Visit www.32bjfunds.org, or Log onto the Member Portal at www.32bjmemberportal.org
To pre-certify: • a hospital or medical stay • a mental health or substance abuse stay	WebTPA	Call 1-866-975-9456
To help prevent or report health insurance fraud (hospital or medical)	Anthem Fraud Hotline	Call 1-800-423-7283 9:00 a.m. – 5:00 p.m., Monday–Friday
Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc.	WebTPA	1-877-487-4300

Change in Contact Information of Employer Trustee Page 1: Effective January 1, 2026, Brooke Jenkins-Lewis' contact information is replaced with the following:

Brooke Jenkins-Lewis
Executive Director
NYC School Support Services, Inc.
5 Penn Plaza
19th Floor
New York, NY 10001

Resignation of Union Trustee Page 1: Effective January 31, 2025, Shirley Aldebol has resigned as Union Trustee. Her information is deleted in its entirety.

Appointment of Union Trustee Page 1: Effective January 31, 2025, Roxana Rivera has been appointed Union Trustee. Her information is as follows:

Roxana Rivera
Assistant to the President
32BJ SEIU
26 West Street
Boston, MA 02111

Add additional contact information for Lantern Surgery Care and Progyny, inside of the back cover of the booklet, after Page 156: Under the sub-heading: "Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits" add the following two rows of contact information:

WHAT DO YOU NEED?	WHO TO CONTACT	HOW
For certain mandatory surgeries such as bariatric, joint replacement, and spine and other voluntary surgeries	Lantern Surgery Care	Call 855-413-7197 Monday- Friday 6 a.m. to 10:00 p.m. CT
Fertility Services	Progyny	Call 866-960-3601 Monday- Friday 9 a.m. to 9:00 p.m. ET Progyny Rx Pharmacists 24/7

Change in Section 2: HEALTH BENEFITS (Medical, Hospital, Behavioral Health and Substance Abuse) AND ANCILLARY HEALTH BENEFITS (Prescription Drug, Dental and Vision), "A. Introduction", Page 23: Effective January 1, 2026, in the first bullet point under the header "1. What Benefits Are Provided," the reference to "Anthem Blue Cross Blue Shield" is replaced with "WebTPA"

Change in "Annual Out-of-Pocket Maximum on In-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) and Pharmacy Benefits", Page 24: Effective January 1, 2026, a new paragraph is added following the third paragraph in that section that begins "In 2025," as follows:

In 2026, your total individual annual **in-network** out-of-pocket maximum will be $10,600 and your family's annual **in-network** out-of-pocket maximum will be $21,200. These amounts may change from year to year.

Change in "Annual Out-of-Pocket Maximum on In-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits", Page 24: Effective January 1, 2026, a new paragraph is added following the second paragraph in that section that begins "In 2025," as follows:

In 2026, your annual out-of-pocket maximum for individual **in-network** health benefits will be $7,950, and your family's annual out-of-pocket maximum for **in-network** health benefits will be $15,900. In 2026, after a family has spent $15,900 in out-of-pocket costs for **in-network** health benefits, regardless of how much each family member paid in out-of-pocket costs for **in-network** health benefits, there will be no additional out-of-pocket costs (**copays**) for any additional **in-network** health benefits during the calendar year.

Change in "Annual Out-of-Pocket Maximum on In-Network Prescription Drug Benefits", Page 25: Effective January 1, 2026, a new paragraph is added following the second paragraph in that section that begins "In 2025," as follows:

In 2026, your annual out-of-pocket maximum for individual **in-network** prescription drug benefits will be $2,650, and your family's annual out-of-pocket maximum for prescription drug benefits will be $5,300. In 2026, after a family has spent $5,300 in out-of-pocket costs for covered prescription drugs, there will be no additional out-of-pocket costs for any additional covered prescription drugs during the calendar year.

Change in "Annual Out-Of-Pocket Maximum on Out-of-Network Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits", Page 26: Effective January 1, 2026, a new paragraph is added following the second paragraph in that section that begins "In 2025," as follows:

In 2026, your annual out-of-pocket maximum for individual **out-of-network** health benefits will be $10,600, and your family's annual out-of-pocket maximum for **out-of-network** health benefits will be $21,200. In 2026, after a family has spent $21,200 in out-of-pocket costs for **out-of-network** medical benefits, regardless of how much each family member paid in out-of-pocket costs for **out-of-network** health benefits, there will be no additional out-of-pocket costs (**deductibles** or **co-insurance**) for any additional **out-of-network** health benefits during the calendar year, except that this will not prevent an **out-of-network provider** from balance billing a participant for charges in excess of the **allowed amount**.

Change in Section 2: HEALTH BENEFITS (Medical, Hospital, Behavioral Health and Substance Abuse) AND ANCILLARY HEALTH BENEFITS (Prescription Drug, Dental and Vision), "B. Health Benefits: Hospital, Medical, Behavioral Health and Substance Abuse Benefits", Page 27: Effective January 1, 2026, under the header "1. How the Health Benefit Works," the first paragraph is deleted in its entirety and replaced with:

The Plan provides health benefits including hospital, medical, behavioral health and substance abuse benefits, which are administered by WebTPA. WebTPA will be referred to as the "**claims administrator**" throughout this document. Benefits are available on both an **in-network** and **out-of-network** basis and are described in detail in this section. How much you pay out-of-your own pocket for covered medical expenses will depend on whether you use an **in-network** or **out-of-network provider**.

Change in "Nurses Healthline", Pages 3, 27, and 30: Effective January 1, 2026, the Nurses Healthline is discontinued, and as a result, the Table of Contents reference on page 3 that reads "Nurses Healthline" is deleted, the third sentence on page 27 under the header "Id Card" that refers to access to 24-hour nursing services is deleted, and the section on page 30 describing the Nurses Healthline is deleted.

Change in "Out-of-Network Benefits", Page 31: Effective January 1, 2025, in the immediate paragraph under the sentence, "You will pay more when you use an out-of-network provider", the text that states "It is the amount paid for a medical service in a geographic area based on the average county rate for **facilities** and the **in-network** PPO rate for **health care providers."** is deleted and replaced with the following:

The maximum **allowed amount** for office visits is 110% of Medicare rates and the maximum **allowed amount** for facility visits is 125% of Medicare rates. The **allowed amount** for non-acute care facilities for both in and out-of-area will be the pricing accepted by local plans within the area. The **allowed amount** for other (codes with no Medicare Rate) Cost to Charge ratio, generally defined as cost divided by charges.

Change in "*Annual co-insurance maximum*", Page 33: Effective January 1, 2026, a new sentence is added after the fourth sentence as follows:

In 2026, your annual **co-insurance** maximum will be $6,950 and your family **co-insurance** maximum will be $13,225.

Change in "*Example of What You Could Pay When You See an Out-of-Network Provider*", Page 35: The chart under this section is replaced with the chart below:

Provider Charge for Surgery	$17,000
Allowed amount for Surgery	$1,450
You pay the **deductible**	$1,000
You also pay 50% of the **allowed amount** after your **deductible** (**co-insurance**)	$1,450 - $1,000 = $450 $450 x 50% = $225
You also pay the difference between the **allowed amount** and the **provider** charge	$17,000 - $1,450 = $15,550
Total Amount You Owe	$1,00 + $225 + $15,550 = $16,775
Plan pays 50% of the **allowed amount** after your **deductible**	$1,450 - $1,00 = $450 $450 x 50% = $225
Total Amount the Plan Pays	**$225**

Change in "Type of Care that Requires Pre-authorization", Page 40: Effective January 1, 2026, the table under the header "**6. Pre-authorization for Health (Hospital, Medical, Behavioral Health and Substance Abuse) Benefits**" is deleted in its entirety and replaced with:

Type of Care that Requires Pre-authorization	**When You Must Call**
Inpatient Admissions • Acute Care Hospital • Long-term Acute Care (LTAC) • Acute Physical Rehab • Skilled Nursing Facility • Behavioral Health / Substance Abuse • Residential Treatment Center (RTC)	For Emergency Admissions: Within 48 hours of admission For Elective Admissions: Two weeks before you receive surgery/care or as soon as possible

• Hospice	*** For maternity admissions lasting longer than two days for normal delivery, or four days for cesarean section, as soon as you know care will last longer than originally planned.
Behavioral Health / Substance Abuse • Partial Hospitalization Program (PHP) • Intensive Outpatient Program (IOP)	Two weeks before you receive care or as soon as care is scheduled.
Transplant Evaluations and Admissions (excluding corneal)	Two weeks before you receive care or as soon as care is scheduled.
Medications *(Administered through the hospital/medical benefit)* • Includes CAR-T Therapy and Gene Therapy	Two weeks before you receive care or as soon as care is scheduled.
Outpatient Services Imaging & Diagnostics • CT scans • MRI / MRA • Nuclear scans • PET scans • Genetic Testing	As soon as possible before you receive care.
Durable Medical Equipment (DME) • Custom Orthotics / Prosthetics / Braces • Bone Growth Stimulators • Electrical Stimulation Devices (TENS / NMES / EMS / FES) • Hospital Beds and Accessories • Negative Pressure Wound Therapy / Vacuum-Assist (VAC) • Pressure Reducing Surfaces • Seat Lift Mechanisms • Vagus Nerve Stimulation Device (VNS) • Bone-anchored Hearing Aids (BAHA) • Power Wheelchair and Accessories	As soon as possible before you receive care.
Air Ambulance (Scheduled Transport Only)	As soon as possible before you receive care.
Therapies (habilitative therapy is NOT covered) • Physical therapy - medical necessity review after 12 visits (30 / year)	As soon as possible before you receive care.

• Occupational therapy - medical necessity review after 12 visits (30 combined OT/ST/Vision / year) • Applied Behavioral Analysis (ABA) therapy	
Outpatient Procedures • Radiation Therapy **Interventional Pain Management** • Spinal Epidurals • Spinal Facet Joint Blocks • Spinal Facet Joint Radiofrequency Neurolysis • Nerve Stimulator Insertion • Spinal Cord Stimulator Insertion	As soon as possible before you receive care.
Cochlear Implants	As soon as possible before you receive care.
Cardiovascular • Defibrillator placement (defibrillator checks do not require precert) • Pacemaker placement (pacemaker checks do not require precert) • Cardiac ablation	As soon as possible before you receive care.
Musculoskeletal (carved out to Lantern) • Joint Replacement surgeries • Spine surgeries	Two weeks before you receive surgery or as soon as care is scheduled.
Obesity/Bariatric Surgery (carved out to Lantern)	Two weeks before you receive surgery or as soon as care is scheduled.
Gender Affirmation • Genital surgery • Gonadectomy • Breast / Chest surgery (Tattooing included) • Facial surgery • Body contouring • Hair removal • Voice Therapy (ST benefit applies)	Two weeks before you receive surgery or as soon as care is scheduled.
Cosmetic Procedures deemed medically necessary • Blepharoplasty / Ptosis repair • Bone graft, genioplasty, mentoplasty	Two weeks before you receive surgery, or as soon as care is scheduled.

• Breast surgery • Canthopexy / Canthoplasty • Cervicoplasty • Chemical Peels • Dermabrasion • Dermal fillers • Excision of excess skin or tissue • Hair transplant • Lipectomy/Liposuction • Lipoma excision • Otoplasty • Orthognathic surgeries • Panniculectomy/Abdominoplasty • Rhinoplasty or septoplasty • Rhytidectomy • Scar revision • Sclerotherapy • Skin grafts/skin flaps/tissue grafts • Skin lesion removal-phototherapy/laser therapy • Skin substitutes • Varicose vein treatment (excluding stab phlebectomy)	
For the following mandatory surgeries: • Bariatric • Joint (hip, knee, ankle, and shoulder) • Spine	You must contact Lantern Surgery Care at 855-413-7197 for pre-authorization for these surgeries as soon as you know you will need surgery. These surgeries must be performed by a Lantern Surgery Care provider or you will have to pay the entire cost of the surgery unless a distant exception applies (see Section 2.G. Surgical Benefits Through Lantern Surgery Care).
For the following voluntary surgeries: • Orthopedic (other than joint replacement) • Otolaryngology (ear, nose, and throat) surgeries • Cardiac • Gynecology • General surgery • Gastrointestinal • Spine and ortho injections to manage pain (non-surgical procedures) • Urology	You may contact Lantern Surgery Care at 855-413-7197 for pre-authorization for these surgeries as soon as you know you will need surgery. If surgeries are performed by a Lantern Surgery Care provider you will have a $0 **copay**. If you do not use Lantern Surgery Care for these surgeries, please contact the **claims administrator** for pre-authorization two weeks before you receive surgery, or as soon as care is scheduled.

Change in "Type of Care that Requires Pre-authorization", Page 40: Effective January 1, 2025, the below is added to column 1, row 2:

For the following surgeries:

- Bariatric
- Joint (hip, knee, ankle and shoulder)
- Spine

you must contact Lantern Surgery Care at 855-413-7197 for pre-authorization.

For the below surgeries, you may choose to receive care from Lantern Surgery Care for a $0 **copay**:

- Orthopedic (other than joint replacement)
- Otolaryngology (ear, nose, and throat) surgeries
- Cardiac
- Gynecology
- General surgery
- Gastrointestinal
- Spine and ortho injections to manage pain (non-surgical procedures)
- Urology

If you choose to receive care from Lantern Surgery Care, contact Lantern Surgery Care at 855-413-7197 for pre-authorization.

If you do not choose to receive care from Lantern Surgery Care for one of the above voluntary surgeries or for any other surgery, please contact the **claims administrator**.

The mandatory surgeries listed above must be performed through Lantern Surgery Care to be covered. If you do not use a Lantern doctor for a mandatory surgery listed above, you will have to pay the entire cost of the surgery.

Change in "In the Hospital and Other Inpatient Treatment Centers", Page 42: Effective January 1, 2025, the below is added under the sub-header "Additional Information and Limitations" where it reads "The following are not covered:":

In the Hospital and Other Inpatient Treatment Centers

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Additional Information and Limitations
			- Mandatory surgeries that must be performed at a 32BJ Health Fund Center of Excellence by a 32BJ Health Fund Center of Excellence

			provider through Lantern Surgery Care,

Change in "In the Hospital and Other Inpatient Treatment Centers (continued)", Page 43:
Effective January 1, 2025, for the row entitled "Bariatric surgery", the corresponding columns are deleted in their entirety and replaced with:

In the Hospital 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 performed at a 32BJ Health Fund Center of Excellence by a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care, or if there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address, and you are granted a distance exception before your surgery.	Not covered.	Pre-authorization required. Only covered if performed at a 32BJ Health Fund Center of Excellence with a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care as described in the "**In-Network Hospital or Facility"** column. Call Lantern Surgery Care for more information. Contact Lantern Surgery Care at 855-413-7197 for pre-authorization.

Change in "In the Hospital and Other Inpatient Treatment Centers (continued)", Page 44:
Effective January 1, 2025, in the column entitled "Benefit" for the row entitled "Joint Replacement (hip and knee)", the language is deleted in its entirety, as is its corresponding columns, and replaced with the below:

In the Hospital and Other Inpatient Treatment Centers (continued)

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Joint Replacement (hip, knee, ankle, and shoulder)	Plan pays 100% if surgery is performed at a 32BJ Health Fund Center of Excellence by a 32BJ Health Fund	Not covered.	Pre-authorization required. Only covered if performed at a 32BJ Health Fund Center of Excellence with a 32BJ

	Center of Excellence provider through Lantern Surgery Care, or if there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address, and you are granted a distance exception before your surgery.		Health Fund Center of Excellence provider through Lantern Surgery Care. Contact Lantern Surgery Care at 855-413-7197 for pre-authorization and information on $0 copay virtual physical therapy through Hinge Health or see the SPD section entitled "Physical, Occupational, Speech or Vision Therapy (including rehabilitation)."

Change in "In the Hospital and Other Inpatient Treatment Centers (continued)", Page 45:
Effective January 1, 2025, a new row is added to the table as below:

In the Hospital and Other Inpatient Treatment Centers (continued)

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Spine surgery	Plan pays 100% if surgery is performed at a 32BJ Health Fund Center of Excellence by a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care, or if there is no 32BJ Health Fund Center of Excellence within 50 miles of your home address, and you are granted a distance exception before your surgery.	Not covered.	Pre-authorization required. Only covered if performed at a 32BJ Health Fund Center of Excellence with a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care. Contact Lantern Surgery Care at 855-413-7197 for pre-authorization and information on $0 copay virtual physical therapy through Hinge Health or see the SPD section entitled "Physical, Occupational, Speech or Vision Therapy

			(including rehabilitation)."

Change in "Emergency Care", Page 46: Effective January 1, 2026, in the second row under "Out-of-Network Hospital or Facility" the text is amended from "Plan pays 50% of the **allowed amount** and the member pays 50%..." to read as below:

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
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 any charges above the **allowed amount**.	If the urgent care center bills your visit as an Emergency room visit, you will pay the ER **copay**.

Change in "Outpatient Treatment Facilities", Page 47: Effective January 1, 2026, in the first row, the text in the "Limitations" box is deleted in its entirety and this row now reads:

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 any charges above the **allowed amount**.	

Change in "Outpatient Treatment Facilities (continued)", Page 48: Effective January 1, 2026, in the last row, the text in the "Limitations" box is deleted in its entirety and this row now reads:

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Sleep Studies	Plan pays 100% after $75 **copay** at an **in-network preferred facility**. Plan pays 100% after $250 **copay** at an **in-network non-preferred facility**.	Plan pays 50% of the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	

Change in "Care in the Doctor's Office", Page 49: Effective January 1, 2025, in the row entitled "Allergy care" under the "Limitations" column, the text that reads "Limited to 12 treatment visits…" is replaced with "Limited to 90 treatment visits…" as shown below:

Benefit	In-Network	Out-of-Network	Limitations
Allergy care	Plan pays 100% for office visits with a 5 Star Center Provider. Plan pays 100% after $40 **copay** for office visits with **in-network providers**.	Plan pays 50% of the **allowed amount** and the member pays 50% after the **deductible** and any charges above the **allowed amount**.	Limited to 90 treatment visits per calendar year, plus up to two testing visits per calendar year for allergy care. A third testing visit may be covered if medically necessary. Contact WebTPA at 877-487-4300 for information on coverage for a third testing visit.

Change in "Preventive Medical Care", Page 52: Effective January 1, 2026, the second paragraph beginning with "The range of preventive…" is replaced with the below:

The range of preventive care services covered at no cost share when provided by **in-network health care providers** is designed to meet federal requirements. The Department of Health and Human Services decided which services to include for coverage as preventive medical care based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) Guidelines. With respect to vaccines, the Plan covers vaccines consistent with federal guidelines or applicable state guidelines to the extent that the state where you receive the vaccine provides for more extensive vaccine coverage.

Change in "Pregnancy, Maternity and Newborn Care", Page 56: Effective January 1, 2026, under the "Limitations" column corresponding to the row entitled "Breast pump," the text "within a 270-day period" is deleted, and this row now reads:

Benefit	In-Network	Out-of-Network	Limitations
Breast Pump	Plan pays 100% for two covered models only when obtained from www.edgepark.com	Not covered.	Two breast pumps per pregnancy. Breast pump coverage limited to two identified models when obtained from Edge Park.

Change in "Physical, Occupational, Speech or Vision Therapy (including rehabilitation)", Page 58: Effective January 1, 2025, in the column entitled "In-Network Hospital or Facility" for the row entitled "Doctor's office", the language is deleted in its entirety and replaced with:

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

Benefit	In-Network Hospital or Facility	Out-of-Network Hospital or Facility	Limitations
Doctor's office	Plan pays 100% for office visits with a 5 Star Center Provider for occupational, speech, and vision therapy. A combined maximum of 30 occupational, speech, or vision therapy is covered per calendar year. Copay is waived for virtual physical therapy through Hinge Health received within 12 months before or after a surgery that was performed at a 32BJ Health Fund Center of Excellence by a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care and the provider refers you for physical therapy. **Copay** is waived for physical therapy at a **doctor**'s office received within the first 50 days after **hospital** discharge for a total joint replacement (hip, knee, ankle, or shoulder) surgery (or 120 days after **hospital** discharge for a spine surgery) that was performed at a 32BJ Health Fund Center of Excellence with a 32BJ Health Fund Center of	Not covered.	Pre-authorization required for physical and occupational therapy.

	Excellence provider through Lantern Surgery Care. There is a $40 **copay** for each physical therapy session received after the first 50 days after **hospital** discharge (or 120 days after **hospital** discharge for a spine surgery). A maximum of 30 physical therapy sessions are covered per calendar year.		

Change in "Excluded Health (Hospital, Medical, Behavioral Health and Substance Abuse) Expenses", Page 64: Effective January 1, 2025, the sub-bullet beginning with "bariatric surgery" is deleted in its entirety and replaced with:

- bariatric surgery, unless performed by a health care provider that is a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care and performed at a facility that is a 32BJ Health Fund Center of Excellence (or the Plan granted a distance exception before your surgery),

Change in "Excluded Health (Hospital, Medical, Behavioral Health and Substance Abuse) Expenses", Page 65: Effective January 1, 2025, the sub-bullet beginning with "inpatient joint replacement surgery" is deleted in its entirety and replaced with:

- inpatient joint replacement surgery (hip, knee, ankle, and shoulder), unless performed by a health care provider that is a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care and performed at a facility that is a 32BJ Health Fund Center of Excellence (or the Plan granted a distance exception before your surgery),

Change in "Excluded Health (Hospital, Medical, Behavioral Health and Substance Abuse) Expenses", Page 65: Effective January 1, 2025, add the following new sub-bullet after the sub-bullet beginning with "inpatient joint replacement surgery":

- spine surgery, unless performed by a health care provider that is a 32BJ Health Fund Center of Excellence provider through Lantern Surgery Care and performed at a facility that is a 32BJ Health Fund Center of Excellence (or the Plan granted a distance exception before your surgery).

Change in "Excluded Health (Hospital, Medical, Behavioral Health and Substance Abuse) Expenses", Page 68: Effective January 1, 2025, the sub-bullet beginning with "bariatric surgery" is deleted in its entirety and replaced with:

- bariatric surgery, total joint replacement surgery, and spine surgery unless the Plan granted a distance exception prior to receiving such services

Change in "2. Types of Out-of-Pocket Costs for Prescription Medication", Page 71: Effective January 1, 2026, a new sentence is added after the second sentence in the last paragraph that begins "Your maximum annual out-of-pocket limit" as follows:

In 2026, your maximum annual out-of-pocket limit for **in-network (*participating*)** prescription medication **copays** will be $2,650 for an individual and $5,300 for a family.

Correction to Section 2.D. Dental Benefits, "5. Schedule of Covered Dental Benefits" in the table called "Repairs", Page 84: Effective June 1, 2024, a change is made to the table to correct previous benefit limitations. The table is deleted in its entirety and is replaced with:

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Crown Repair	Once per tooth in a 24-consecutive-month period.	Plan pays 80% and member pays 20%.	Plan pays lesser of actual charges or 50% of the **allowed amount**, and the member pays 50% of the **allowed amount** and any charges above the **allowed amount.**
Repair or adjustment to partial dentures	Once per appliance in any calendar year.		
• Additions to partial dentures • Replace broken teeth on denture	Twice in any consecutive 12-month period.		

Correction to Section 2.D. Dental Benefits, "5. Schedule of Covered Dental Benefits" in the table called "Orthodontic Services", Page 85: Effective June 1, 2024, a change is made to the table to correct previous benefit limitations. The table is deleted in its entirety and is replaced with:

Benefit	Limitations	Participating Provider (In-Network)	Non-Participating Provider (Out-of-Network)
Orthodontics	Only for children under age 19. One course of treatment*** in a lifetime.	Plan pays 50% up to lifetime maximum** of $1,000. Member pays 50%. One course of treatment*** in a lifetime. Only for children under age 19. At the time the appliance is inserted	Not covered.

Cephalometric film or photographic image obtained intra or extra-orally (orthodontic coverage only)		the Plan pays up to 50% of the lifetime maximum. The Plan pays the remaining amount (up to 50% of the lifetime maximum) at the start of the second year for children under age 19. If a course of treatment is started at age 18, the Plan will only pay up to 50% of the lifetime maximum for the entire course of treatment.	

Addition of "Surgical Benefits Through Lantern Surgery Care", Page 96: Effective January 1, 2025, your Plan includes a new surgical benefit through Lantern Surgery Care. Accordingly, a new section 2.G is added starting on page 96 immediately after the "Fertility Benefits Through Progeny" section:

2.G. Surgical Benefits Through Lantern Surgery Care

Effective January 1, 2025, the 32BJ Health Fund Center of Excellence for Surgery program is partnering with Lantern Surgery Care to offer you and your family many more types of surgeries at no cost to you.

The 32BJ Health Fund Center of Excellence for Surgery program covers two categories of surgeries: mandatory surgeries and voluntary surgeries. Mandatory surgeries must be performed by a Lantern Surgery Care surgeon to be covered under the Plan. If you do not go to a Lantern Surgery Care surgeon, you will have to pay the entire cost of your surgery. The following chart describes the types of surgeries covered under the program:

Mandatory surgeries with a $0 copay	**Voluntary surgeries with a $0 copay**
The following surgeries must be performed by a Lantern surgeon to be covered. If you go to a different doctor, you will have to pay the entire cost of your surgery.	If you go to a Lantern surgeon for a voluntary procedure, you will have a $0 **copay** for surgery. Alternatively, if you were to go to an Anthem surgeon and have your procedure at a **preferred in-network hospital**, you would pay a $100 copay.

• Bariatric • Joint replacement (expanded to include hip, knee, ankle, and shoulder surgeries) • Spine	• Cardiac • Ear, nose, and throat • Gastrointestinal • Gynecological	• Orthopedic (other than joint replacement) • And many general surgeries • Nonsurgical injections for spine and orthopedic pain management (like a lumbar epidural steroid)

Mandatory surgeries must be performed by a Lantern surgeon to be covered under the Plan. If you choose to go to a different surgeon for these surgeries, you will have to pay the entire cost of your surgery. If you do not live within 50 miles of a Lantern surgeon who can provide the procedure, you may be granted a distance exception.

For the voluntary surgeries listed above, you have the option to have the procedure performed through Lantern. The advantage of choosing a Lantern surgeon for a voluntary surgery is that you will have a $0 **copay**. Alternatively, if you were to go to an Anthem surgeon and have your procedure at a **preferred in-network hospital**, you would pay a $100 **copay**.

Both mandatory and voluntary surgeries have a $0 **copay** with Lantern Surgery Care.

If your Lantern doctor recommends that you have physical therapy, you can receive unlimited $0 **copay** virtual physical therapy appointments before and after surgery for up to 12 months with a Hinge physical therapist. You can also receive $0 **copay** in person physical therapy with an Anthem physical therapist for up to 50 days following a mandatory surgery (or 120 days following **hospital** discharge for a spine surgery). After the 50 days or 120 days, as applicable, the in person physical therapy **copay** is $40. The Plan covers a maximum of 30 in person physical therapy visits in a calendar year, and preauthorization is required.

Please note that you will be responsible for regular **copays** for appointments with an Anthem network doctor before and after surgery.

In order for your surgical procedure to be covered under the Center of Excellence for Surgery program, you must schedule your procedure through Lantern Surgery Care. To get started, call a Lantern Care Advocate at 855-413-7197. Lantern will answer questions and help you determine next steps.

Change in "Where to Send Claim Forms", Page 105: Effective January 1, 2026, the first and second rows are deleted in their entirety and replaced with:

Benefit	Filing Address
Health (Hospital, Medical, Behavioral Health and Substance Abuse) (**out-of-network** only; no claim forms are necessary for **in-network** care)	WebTPA Payer ID #75261 P.O. Box 99906 Grapevine, TX 76099-9706 www.webtpa.com

Change in "Where to Send Claim Forms", Page 105: Effective January 1, 2025, a new row is added as below:

Benefit	Filing Address
Mandatory or voluntary surgeries performed by Lantern Surgery Care	Lantern Specialty Care Attn: Member Services 2100 Ross Avenue, Suite 1900 Dallas, Texas 75201

Change in "4. Appealing Denied Claims", Page 111: Effective January 1, 2026, the first five rows are deleted in their entirety and replaced with:

Type of Denied Claim	Level-One Appeal	Level-Two Appeal
Health Services Claims (Medical Judgment)	WebTPA	Independent Review Organization ("IRO")
Health Services Claims (Administrative)	WebTPA	Board of Trustees (This level of appeal is voluntary)
Ancillary Health Services Claims:		
Pharmacy (Medical Judgment)	SlateRx	Independent Review Organization ("IRO")
Pharmacy (Administrative)	SlateRx	Board of Trustees (This level of appeal is voluntary)

Change in "4. Appealing Denied Claims", Page 111: Effective January 1, 2025, a new row is added as below:

Type of Denied Claim	Level-One Appeal	Level-Two Appeal
Health Services Claims for Mandatory or Voluntary Surgeries performed by Lantern Surgery Care (Administrative)	Lantern Surgery Care	Board of Trustees (This level of appeal is voluntary)

Change in "Where to File a Level-One Appeal", Page 113: Effective January 1, 2026, the first two rows are deleted in their entirety and replaced with:

Benefit	Write to:	Or Call

Health (Hospital, Medical Behavioral Health Substance Abuse)	WebTPA P.O. Box 1808 Grapevine, TX 76099-1808	877-487-4300
Pharmacy	SlateRx Appeal Department P.O. Box 608 Hudson, OH 44236 or Fax 1-866-306-4892	866-571-5842

Change in "Where to File a Level-One Appeal", Page 113: Effective January 1, 2025, a new row is added as the below:

Benefit	Write to:	Or Call
Health (surgeries performed through Lantern Surgery Care)	Lantern Specialty Care Attn: Member Services 2100 Ross Avenue, Suite 1900 Dallas, Texas 75201	Appeals are only accepted in writing.

Change in "G. Subrogation and Reimbursement", Page 129: Effective January 1, 2026, the name and address for the subrogation vendor, Carelon Subrogation, is removed in its entirety and replaced with:

The PHIA Group, LLC
P.O. Box 216
Canton, MA 02021

You may also email AccidentLetter@phiagroup.com (Include your PHIA case number in the subject line) or call 888-986-0080 between the hours of 8:00 a.m. and 8:00 p.m. ET, Monday – Friday.

Change in "Glossary", Page 150: Effective April 1, 2026, the definition "Allowed amount" is deleted in its entirety and replaced with:

Allowed amount means the maximum amount that the Fund will pay for a **covered service**. When you go to a **preferred or non-preferred in-network hospital or facility** or **provider**, the **allowed amount** is the amount that has been contractually agreed to by the **preferred or non-preferred in-network hospital or facility** or **provider**.

When you go **out-of-network**, the **allowed amount** for an office visit is 110% of Medicare rates, and for facility visits, the **allowed amount** is 125% of Medicare rates. The **allowed amount** for non-acute care facilities for both in and out-of-area will be the pricing accepted by local plans within the area. The

allowed amount for other (codes with no Medicare Rate) Cost to Charge ratio, generally defined as cost divided by charges.

Change in "Glossary", Page 150: Effective April 1, 2025, the definition "Allowed amount" is deleted in its entirety and replaced with the below:

Allowed amount means the maximum amount that the Fund will pay for a **covered service**. When you go to a **preferred in-network hospital or facility** or **provider**, the **allowed amount** is the amount the **claims administrator** and the **preferred in-network hospital or facility** or **provider** have contractually agreed upon. When you go to a **non-preferred in-network hospital or facility,** the **allowed amount** is the lesser of the contractually agreed upon amount and the actual billed amount.

When you go **out-of-network**, the **allowed amount** for an office visit is 110% of Medicare rates, and for facility visits, the **allowed amount** is 125% of Medicare rates. The allowed amount for non-acute care facilities for both in and out-of-area will be the pricing accepted by local plans within the area. The allowed amount for other (codes with no Medicare Rate) Cost to Charge ratio, generally defined as cost divided by charges.

Change in "Glossary", Page 150: Effective January 1, 2026, the definition of "Claims Administrator" is amended to replace references to "Anthem Blue Cross Blue Shield" or "Anthem" with "WebTPA" and it now reads in its entirety as follows:

Claims administrator is WebTPA. WebTPA is the third-party administrator the Board of Trustees has contracted with to process healthcare (hospital, medical, behavioral health and substance abuse) claims. Anthem is the network used for participants who reside within the New York, New Jersey and Connecticut services area which is referred to as the Blue Cross Blue Shield Direct Point-of-Service ("POS") network. Anthem is also the network for those participants who reside outside the New York, New Jersey and Connecticut services area, which is referred to as the Preferred Provider Organization ("PPO") network. For services performed by Lantern Surgery Care, Lantern Surgery Care is the **claims administrator**. For all other usage of "claims administrator," WebTPA is the **claims administrator**.

Change in "Glossary", Page 150: Effective January 1, 2025, the definition "Claims Administrator" is amended to add the below:

For services performed by Lantern Surgery Care, Lantern Surgery Care is the claims administrator. For all other usage of "claims administrator," Anthem is the claim administrator.

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