HEALTH AND WELFARE BENEFITS

THE STEAMFITTERS' INDUSTRY WELFARE FUND

APRIL 2022

Printed in U.S.A.

THE STEAMFITTERS' INDUSTRY WELFARE FUND

General Office

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725
Telephone: (212) 465-8888
FundOffice@steamny.com

www.steamfitters.com

Fund Administration

William J. Turnbull, Executive Administrator
James J. Ippolito, Assistant Administrator
James C. White, Assistant Administrator

TRUSTEES OF THE WELFARE FUND

Employee Trustees

Michael Mulvaney
Daniel Mulligan
Clifford J. Ryder, Jr.
James R. Sheeran, Jr.

Enterprise Association
Steamfitters' Local Union 638
27-08 40th Avenue, 4th Floor
Long Island City, NY 11101-3725

Employer Trustees

Anthony Saporito
Edward English
Shane McMorrow

Mechanical Contractors Association of New York, Inc.
535 Eighth Avenue, 17th Floor
New York, NY 10018-1716

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THE STEAMFITTERS' INDUSTRY WELFARE FUND

Effective January 1, 2022

SUMMARY PLAN DESCRIPTION

The purpose of this booklet is to provide you with the provisions and benefits of The Steamfitters' Industry Welfare Fund. The benefits summarized in this booklet are effective as of January 1, 2022. This booklet replaces and supersedes any prior booklets describing your benefits from the Fund. The provisions of the Plan Document governing the Fund and the various contracts with benefit providers or insured certificates, or insurance contracts govern the payment of all benefits, and the Plan Document and full contracts with benefit providers or insured certificates or insurance contracts should be consulted if you have any questions regarding your benefits. Copies of the Plan Document and all contracts with benefit providers or insured certificates or insurance contracts pertaining to the Plan are available for your inspection and copying at the Fund Office. If there is any difference between this booklet and the Plan Document or contracts with benefit providers, insured certificates or insurance contracts, the provisions of the Plan Document, contracts and certificates will govern.

To All Participants in the Steamfitters' Industry Welfare Fund:

The Steamfitters' Industry Welfare Fund has been designed specifically to protect the health and welfare of you and your families. The effective communication of your health and welfare benefits is a vital element in the overall success of the Plan to you and to the entire group. This booklet will describe those benefits for you.

The Trustees of The Steamfitters' Industry Welfare Fund are proud of the current Plan. The participants we represent can be assured of our continuing effort to further improve the Plan while keeping it on a sound financial basis.

If you have any questions that are not answered by the material contained in this booklet, we encourage you to contact the Fund Office or any of the Trustees.

The Trustees of the Steamfitters' Industry Welfare Fund

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Enterprise Association
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27-08 40th Avenue, 4th Floor
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GENERAL INFORMATION ABOUT THE PLAN

Identifying the Plan:

The full, official name of the Plan is "The Steamfitters' Industry Welfare Fund," but many participants simply refer to it as the "Welfare Fund," "Health Plan," or the "Plan." The Plan is administered by a joint Board of Trustees composed of Employee and Employer Trustees.

Name, Address, Telephone Number, and Email Address of the Board of Trustees, the Plan Administrator and the Plan Sponsor:

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, New York 11101-3725
Phone: (212) 465-8888
Email: FundOffice@steamny.com

The Trustees as of the printing of this booklet are Edward English, Shane McMorrow, Daniel Mulligan, Michael Mulvaney, Clifford J. Ryder, Jr., Anthony Saporito and James R. Sheeran, Jr.

Type of Plan:

This Plan is multiemployer group health plan that includes hospital expense benefits, medical expense benefits, prescription drug benefits, dental benefits, vision care and hearing aid benefits, life insurance and accidental death and dismemberment benefits, and a health reimbursement account fund.

Employer Identification Number of the Plan: 13-1545680

Plan Number: 502

Plan Year Ends: December 31

Type of Administration: Self-Administered

Agent for Service of Legal Process:

William J. Turnbull, Executive Administrator
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, New York 11101-3725
Phone: (212) 465-8888

Service of legal process may also be made on any of the Trustees.

Collective Bargaining Agreement:

The Fund is maintained pursuant to collective bargaining agreements between the Enterprise Association of Steam, Hot Water, Hydraulic, Sprinkler, Pneumatic Tube, Ice Machine and General Pipe Fitters of New York and Vicinity, Local Union 638 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada "Union" and the Mechanical Contractors Association of New York, Inc., "MCA" and other employers. Copies of these agreements may be obtained upon written request to the Fund Executive Administrator and may be examined at the Fund Office or Union Office. The Fund will provide information as to whether an employer is a contributing employer and, if it is, its address, once a written request for this information is made to the Executive Administrator. Upon written request to the Executive Administrator, a complete list of sponsoring employers and employee organizations will be provided.

Source of Financing:

The Fund is financed by contributions received from employers who employ steamfitter participants covered by a collective bargaining agreement. The amount of this contribution is determined by the agreement.

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to covered participants and eligible beneficiaries and for defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies with vendors.

Plan assets are invested under the direction of the Trustees of the Welfare Fund.

Plan Text:

This booklet provides you with the provisions and benefits of the Welfare Plan. This SPD is not a substitute for the Plan Document that governs the Welfare Plan, insurance policies that the Fund has with benefit providers or insured certificates or insurance contracts. In the event of any actual or perceived conflict between the Plan Document, contracts with benefit providers or insured certificates or insurance contracts and this booklet, the terms and conditions of the Plan Document, contracts with benefit providers or insured certificates or insurance contracts will control.

Trustee Discretion:

In carrying out their respective responsibilities under the Plan, the Trustees or any sub-committee or designee(s) appointed by the Trustees, the Executive Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

No Liability for the Practice of Medicine:

The Plan, the Trustees, or any sub-committee or designee(s) appointed by the Trustees, the Executive Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack of care, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees nor any sub-committee or designee(s) appointed by the Trustees, the Executive Administrator or other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated will have any liability whosoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Plan Amendments and Termination of the Plan:

No amendment or termination will deprive a Participant, Beneficiary or Qualifying Dependent of any benefit which has already become payable under the Plan, but it could deprive them of future benefits. The Fund reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively (as opposed to prospectively) except in certain instances, such as you or your covered dependent(s) commits fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Executive Administrator or his designee(s)). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice. Failure to inform the Fund Office that you or your dependent is covered under another group health plan or knowingly provide false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium or contribution toward the cost of coverage including COBRA.

Welfare benefits do not vest, and the Trustees reserve the right to amend or terminate the Plan, or any part of it, at any time for any reason without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- The Board of Trustees may amend the terms of the Plan by adopting a written amendment to the Plan Document, effective as of the date specified in the document amending the Plan Document.

- The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverage(s) may be added by the Board of Trustees.

Allocation and Disposition of Assets Upon Termination:

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by the Welfare Plan.

- To alter or postpone the method of payment of any benefit.

- To amend or rescind any provision of the Plan Document.

In addition, the Plan may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

For Information or Assistance:

If you require any information or assistance, please contact the Fund Office at (212) 465-8888 or by email at FundOffice@steamny.com.

Information on the Steamfitters' Industry Welfare Fund, and all your employee benefit programs, can be found on the Fund Office website **www.steamfitters.com.** You may view your personal benefit information at any time by accessing your member login account on the website.

By accessing your member account, you may also: track employer contributions, view work history, review benefit payments, view Cash Fund balances, check eligibility status, view all Fund Office correspondence and documents, update dependent and beneficiary information, upload important documents (marriage and birth certificates, social security

cards, etc.), instantly update your address and contact information, file and submit disbursement forms digitally, message the Fund Office and more.

PLAN INFORMATION OVERVIEW	
General Plan Information and Eligibility ♦ Eligibility ♦ Information about USERRA, FMLA, QMCSOs and your Rights under the Plan ♦ Request documents or other Plan related information ♦ General questions about Plan coverage **COBRA Information** **HIPAA Privacy Information**	***Program Administered By:*** **Steamfitters' Industry Welfare Fund**
Life Insurance and Accidental Death and Dismemberment Benefits	***Benefits Provided By:*** **MetLife** ***Submit Application To:*** **Steamfitters' Industry Welfare Fund**
Medical and Hospital Benefits ***[Active & Non-Medicare Eligible Retirees]***	***Benefits Provided By:*** **Empire BlueCross BlueShield EPO**
Medical, Hospital and Prescription Drug Benefits ***[Medicare Eligible Retirees Only]***	***Benefits Provided By:*** **Empire MediBlue Freedom Plan PPO**
Prescription Drug Program	***Benefits Provided By:*** **Express Scripts, Inc.**
Dental Benefits	***Benefits Provided By:*** **MetLife**
Vision Care & Hearing Aid Benefit	***Benefits Provided By:*** **Steamfitters' Industry Welfare Fund**
Health Reimbursement Account	***Benefits Provided By:*** **Steamfitters' Industry Welfare Fund**

ACTIVE ELIGIBILITY

Who is Eligible for Coverage?

Three groups of individuals are eligible to participate in the Steamfitters' Industry Welfare Fund. They are:

1. Any journeyman steamfitter, apprentice or Helper* whose employment is covered by a collective bargaining agreement between Enterprise Association Local Union 638 and an employer obligated to contribute to the Steamfitters' Industry Welfare Fund;
2. A salaried official of Enterprise Association Local Union 638 on whose behalf contributions are being made to the Welfare Fund by the Union; or
3. An employee of the Steamfitters' Industry Educational Fund or the Welfare Fund on whose behalf contributions are made to the Welfare Fund in accordance with a Participation Agreement.

*The Helper category is eligible for individual health coverage only (no dependents are covered). In addition, Helpers do not receive contributions to the Health Reimbursement Account. Hours worked by a Helper in covered employment will be credited to the participant if he or she is upgraded to an apprentice.

When Does My Coverage Become Effective?

You are covered on the first day of the second calendar quarter following any period of four or less consecutive calendar quarters in which you work in covered employment for 1,000 hours for an employer or employers obligated to contribute to the Welfare Fund.

Example:

- You start work in covered employment in January.
- Between January 1 and June 30, you are paid for 1,000 hours in covered employment.
- You allow for the waiting period of one calendar quarter – from July 1 to September 30.
- Your coverage becomes effective on October 1.

NOTE: You do not have to meet the requirement of 1,000 paid hours in a particular calendar quarter in order to qualify for coverage. If you work in covered employment for a total of 1,000 hours in any four, or less, **consecutive** calendar quarters, you will qualify for coverage.

Coverage Eligibility Example:

You start work in covered employment in January.

January 1 to March 31	You are paid for	370 Hours
April 1 to June 30	You are paid for	0 Hours
July 1 to September 30	You are paid for	450 Hours
October 1 to December 31	You are paid for	180 Hours
	Total Paid Hours	**1,000 Hours**

You allow for the waiting period of one calendar quarter from January 1 to March 31. *Your coverage becomes effective on April 1.*

How Often Is My Coverage Reviewed?

Eligibility for coverage in the Welfare Fund is reviewed quarterly.

How Do I Maintain Coverage?

Once your ***initial*** coverage begins, it lasts for at least one year from the time your coverage begins. Thereafter, your hours are reviewed at the end of each calendar quarter. You will continue to be covered as long as you work in covered employment for 1,000 hours during every four consecutive calendar quarters.

When Will a Participant's Coverage Terminate?

If you do not work in covered employment for the required 1,000 hours within four consecutive calendar quarters, your coverage will terminate at the end of the next calendar quarter.

For Example:

You were covered through all of 2020. You worked the following hours in 2021:

January 1 to March 31, 2021	You are paid for	370 Hours
April 1 to June 30, 2021	You are paid for	180 Hours
July 1 to September 30, 2021	You are paid	370 Hours
October 1 to December 31, 2021	You are paid for	0 Hours
	Total Paid Hours	**920 Hours**

A total of 1,000 paid hours of work in covered employment, within four consecutive calendar quarters, ***has not*** been achieved; therefore, the last day of coverage is *March 31, 2022.*

EXCEPTION TO THE 1,000-HOUR ELIGIBILITY RULE:

There is a "one-time exception" to the 1,000-hour eligibility rule, as follows:

One-Time "Career Extension": At the first quarterly eligibility review in which the number of your aggregate hours earned during the review falls below 1,000 but equals or exceeds 800 hours, you will be granted automatically a one-quarter extension of your eligibility. **This extension shall not be granted more than once in your career**.

Can My Benefits be Suspended or Terminated?

A) If you are found guilty of committing any of the following acts, except as stated in Section B, you and your dependents will be suspended from all coverage for a period of three (3) years for the first offense and permanently for any subsequent offense, as determined by the Trustees:

- Performing work covered by Local 638's Collective Bargaining Agreement for a non-signatory employer;
- Receiving a cash payment in lieu of contributions that your employer is required to make to the Fund;
- Knowingly conspiring, aiding or assisting an employer to avoid payment of contributions;
- Defrauding the Fund of any payment to which the Fund is entitled;
- Knowingly conspiring, aiding or assisting a doctor or any other person in defrauding the Fund;
- Fraudulently obtaining coverage or benefits from the Fund that you or your dependent(s) are not entitled to.

B) If you are found guilty of submitting a claim based upon a misrepresentation or fraud for a particular benefit, you and your dependents will be suspended from all coverage for that benefit for a period of one (1) year for the first offense and two (2) years for any subsequent offense, as determined by the Trustees. The participant's dependents will not lose coverage under this Section.

The Trustees or a group designated by the Trustees will use their discretion in determining when benefits shall be suspended or terminated based on the above.

When a participant or beneficiary is suspended or terminated from coverage, the Fund will not make payments on the participant's behalf, notwithstanding the fact that contributions are required to be paid for such participant during the suspension period. However, coverage will continue during the suspension period for any disability benefits to which a participant may be entitled to under New York State Law.

What Happens If I Lose Coverage?

A federal law, commonly referred to as COBRA, requires that group health plans offer participants and their families whose coverage would otherwise end, the opportunity for a temporary extension of health coverage called "Continuation Coverage" at their own expense. The Federal laws allow a plan to charge a 2% surcharge for continuation coverage. The Welfare Fund will charge those electing COBRA coverage 102 percent of the Fund's cost of coverage.

If your loss of coverage is due to insufficient hours, you and your qualifying dependents may continue coverage for up to 18 months. Participants considering COBRA coverage must request the extended coverage in writing within 60 days from the date the participant is notified of the right to continue coverage.

If a spouse and dependents lose coverage due to the death of an active or retired participant, COBRA continuation coverage is available for up to 36 months.

Divorced or legally separated spouses and dependent children who are no longer covered when they reach the age specified in the Plan may extend coverage for up to 36 months. If you become either divorced, legally separated or your children no longer qualify as dependents, you must notify the Fund Office in writing within 60 days to protect their COBRA rights.

For more details about COBRA, please see the section entitled "Continuation of Coverage - COBRA" that appears later in this booklet. Complete details concerning the COBRA coverage are available from the Fund Office. The government website for general information is dol.gov/cobra.

It is mandatory that you report a divorce to the Fund Office immediately upon entry of a divorce decree or judgment. You will be instructed to submit a full copy of your divorce decree or judgment. If your divorce decree or judgment is not yet available from the court or municipal clerk, you will be required to complete a pre-printed affidavit. The Fund Office cannot accept your verbal notification; you must submit your divorce decree or judgment or complete an affidavit for the divorce to be recognized by the Fund Office.

> ***Please note:*** You will be financially liable for the costs the Welfare Fund should incur due to your non-timely notification or failure to notify the Fund of your divorce.

How Can I Become Covered Again?

Once your coverage terminates, in order to become covered again, you must satisfy the requirements set forth in the answer to the question, *"When Does My Coverage Become Effective?"* on page 9.

What Happens If an Active Participant Becomes Temporarily or Partially Disabled and Unable to Work?

If an active participant, while covered under the Welfare Fund, becomes temporarily or partially disabled and unable to work as a steamfitter, the participant and all eligible dependents will continue to be covered during the period in which the participant is disabled up to a maximum of three years so long as the participant's disability continues, and the participant applies for and meets all of the necessary requirements. This is called the **Disability Status Program.** The Helper classification of participant is not eligible for this program.

The requirements for Welfare Fund coverage under the **Disability Status Program** are as follows:

- You must be unable to practice the trade of steamfitting because of a temporary or partial disability;
- Your application must be received within 30 days of the onset of the disabling condition. Applications received after the 30-day filing period will be rejected. The 30-day filing period applies even if your coverage remains effective in accordance with the standard eligibility requirements;
- You must have been in coverage for at least 10 of the 40 calendar quarters immediately preceding the date on which your application for the Disability Status Program coverage is received by the Fund Office (your application must include the requisite supporting data necessary for the application to be properly filed);
- You must have earned a minimum of ten years of credited service in the Steamfitters' Industry Pension Fund and have earned a year of service in one of the three years immediately prior to the year of the disability (this requirement is waived for all classes of apprentices only);
- Your combined family income (you and your spouse) after the onset of your disability must not exceed $141,024 per year [2,080 hours X (Journeymen Wage Rate + Vacation Wage Rate) on January 1st of each year], adjusted annually, as reported on your most recent income tax returns; and
- You must submit to any and all medical examinations prescribed by the Trustees.

If you recover from your disability and return to work or are deemed medically able to return to work, your coverage remains in effect until the end of the third calendar quarter following the quarter in which such disability status terminates. Work specifically includes any employment under the temporary heat or air conditioning provisions of the collective bargaining agreement.

> ***For Example:***
>
> If your disability ended on November 20, during the calendar quarter ending December 31, your coverage would remain in effect until the following September 30th.

What Is The 40-Year Eligibility Rule?

When you attain 40 years of credited service in the Steamfitters' Industry Pension Fund ***as an active member***, you are permanently covered under the Welfare Fund as of the first of the year after the year in which you obtained your 40th year of credited service, provided that you were covered for at least 20 of 40 calendar quarters immediately preceding the date on which you acquired 40 years of credited service.

What Happens When an Active Participant is on Jury Duty?

A participant shall receive seven (7) hours per day credit towards the 1,000 hours requirement when serving on jury duty provided that no Employer has contributed to the Fund on the participant's behalf for those hours. Documentation of the jury duty service must be in a form acceptable to the Trustees.

What Happens When an Active Participant Receives Benefits Under the New York State Paid Family Leave Law?

For each day a participant is enrolled in New York State Paid Family Leave (NYSPFL) and provides the Fund with official documentation, you will be granted seven (7) hours of credit towards eligibility.

For more information on the NYSPFL please visit ny.gov/paidfamilyleave or call the Paid Family Leave Helpline at (844) 337-6303.

What Happens If I Need FMLA Leave?

Under the Family and Medical Leave Act ("FMLA"), you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child or children, or to care for your seriously ill spouse, parent, or children.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must:

- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

If you qualify, during your FMLA leave your health coverage will be maintained under the Fund. You may be eligible for FMLA leave if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the Employer within 75 miles.

Please contact your Employer and the Fund Office if you are planning to take FMLA leave. Appropriate documentation for FMLA must be provided to your Employer and the Fund Office prior to benefit commencement and/or continuation.

What Happens If I Enter the Uniformed Services?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") applies to a person who perform duty, voluntarily or involuntarily, in the Uniformed Services as well as the reserve components of the Uniformed Services. If you are drafted, activated from reserve status or enlist into the Uniformed Services of the United States (which includes the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service Commissioned Corps, the Army National Guard, and the Air National Guard or any other category designated by the President in time or war or national emergency), your coverage as an active participant will terminate in accordance with regular eligibility rules (see "When Will a Participant's Coverage Terminate").

Your qualified dependents will maintain coverage in the Welfare Fund throughout your service as long as you were covered the day before your service commenced. Although this dependent coverage is not required under USERRA, the Trustees have extended coverage as an additional benefit.

As a participant, if you worked one (1) hour within 90 days immediately prior to entry into service as a covered participant on the date of your entry, the following is applicable:

- If you are on active military duty for 30 days or less, you will continue to receive medical coverage under this Plan.
- If you are on active duty for more than 30 days, USERRA permits you to continue medical, prescription and dental coverage for you and your dependents at your own expense for up to 24 months provided you enroll for coverage. This continuation of coverage operates in the same way as COBRA. (Please refer to the COBRA section of this booklet for details.) In addition, your dependents may be eligible for health care under the Civilian Health & Medical Program of the Uniformed Services (TRICARE). This Plan will coordinate coverage with TRICARE (see the "Coordination of Benefits" section of this booklet).
- You should carefully review the benefits, costs, provider networks, and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing the Plan's benefits under USERRA or COBRA is the best choice.
- When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating Employer for the quarter in which you return to active employment. If you were on active duty for more than 30 days, you must provide proof of military service, such as Form DD-214, upon your return to work with a participating Employer. Additionally, if you meet these requirements, comply with the time limits set forth herein, and your military service was for ninety (90) or more days, you will be eligible for an additional two (2) calendar quarters of coverage.

The time limits for returning to work are as follows:

- **Less than 31 days of Service:** one (1) day after discharge (allowing for 8 hours of travel).
- **31 to 180 days:** 14 days from the date of discharge, if the period of military service was 31 days or more, but less than 181 days (provided that you either returned to work or applied for employment with a participating employer).
- **181 days or more:** 90 days from the date of discharge, if the period of military service is more than 180 days (provided that you either returned to work or applied for employment with a participating employer).

If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Please contact the Fund Office for more details.

> **Please note:** You must provide oral or written advance notice to the Welfare Fund that you are leaving your job for service in the Uniformed Services (unless such notice was precluded by military necessity or otherwise impossible or unreasonable.)

RETIREE ELIGIBILITY

What Happens to My Coverage When I Retire?

Your retiree health coverage is based on the type of pension you select (regular, early or disability) and the qualifications you meet.

❖ "Regular Pension" Retiree Health Coverage Eligibility (age 60+)

In order to qualify for regular pension retiree lifetime health coverage, a participant must have:

a. earned 20 years of credited service in the Steamfitters' Industry Pension Fund, and

b. worked at least a total of 30,000 aggregate life-time hours in the construction trades division, and

c. be covered in the Welfare Fund the day before the pension effective date or 20 of 40 quarters immediately prior to the pension effective date.

❖ "Disability Pension" Retiree Health Coverage Eligibility

In order to qualify for any type of disability pension retiree lifetime health coverage, a participant must have:

a. earned 15 years of credited service in the Steamfitters' Industry Pension Fund, and

b. worked at least a total of 22,500 aggregate life-time hours in the construction trades division, and

c. be covered in the Welfare Fund the day before the pension effective date or 20 of 40 quarters immediately prior to the pension effective date.

❖ "Early Pension" Retiree Health Coverage Eligibility (age 55-59)

There are two types of early pension retiree health coverage: one is lifetime and the other is limited retiree health coverage.

In order to qualify for early pension retiree lifetime health coverage, a participant must have:

a. earned 30 years of credited service in the Steamfitters' Industry Pension Fund, and

b. worked at least a total of 30,000 aggregate life-time hours in the construction trades division, and

c. be covered in the Welfare Fund the day before the pension effective date or 20 of 40 quarters immediately prior to the pension effective date.

In order to qualify for early pension retiree limited health coverage (coverage for participant or dependents only until the earliest of age 65 or Medicare eligibility; if participant coverage terminates, coverage for all dependents simultaneously terminates), a participant must have:

a. earned 20-29 years of credited service in the Steamfitters' Industry Pension Fund, and

b. worked at least a total of 30,000 aggregate life-time hours in the construction trades division, and

c. be covered in the Welfare Fund the day before the pension effective date or 20 of 40 quarters immediately prior to the pension effective date.

For each category of retiree health coverage listed above, the Participant's status is determined as of the date of retirement. The date of retirement shall be deemed to be the first date paid by either the Steamfitters' Industry Pension Fund or the Metal Trades Branch Local 638 Pension Fund for those participants included by virtue of a participation agreement. As qualifying factors for those included based on a participation agreement, years of credited service and aggregate life-time hours of employment shall mean total years of employment since hire date and hours worked for the Steamfitters Industry Trust Funds. A Participant's status remains intact and unalterable after the Participant's date of retirement, regardless of any future employment activity.

What Happens if I Work After Age 65 or Return to Work as a Pensioner?

If you as a pensioner are age 65 or over and return to work or never stop working, your coverage will remain Empire BlueCross EPO and Express Scripts primary, providing you continue working and maintain the 1000 hours eligibility requirements. However, once you cease working, Medicare will become your primary carrier on the first of the month after 45 days of no employment. For example: Your last date of employment is March 2. Empire and Express Scripts will remain your primary coverages until May 1. As of May 1, we will enroll you in our Empire MediBlue Freedom Advantage PPO plan.

It is vital and imperative that if you did not take Medicare Part B at age 65 because you were working, you apply for Medicare before or immediately after you stop working. You will need a Medicare (CMS-L564) form to be completed by the Welfare Fund to confirm that you have had active group health coverage with the Welfare Fund since turning age 65. If you do not promptly apply for Medicare, you will be subject to late enrollment into Medicare and additional premiums that you will be liable to pay to Medicare. More importantly, if you are not enrolled in Medicare, you will no longer have coverage with the Fund.

FOR ALL TYPES OF RETIREE HEALTH COVERAGE:

Your status is determined as of the date of your retirement; that determination may include “no coverage” if you do not meet the criteria. Furthermore, your coverage status remains intact and unalterable after your date of retirement regardless of any future employment activity.

If your participation under the Plan is terminated solely because you leave covered employment to serve in full-time employment with the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada (the “UA”) or the apprenticeship and training program it sponsors, you will be eligible for retiree coverage under this Plan if you were entitled to benefits under this Plan on the day before the date you commenced full-time employment with the “UA”.

DEPENDENT ELIGIBILITY – ACTIVE & RETIREE

Are All of My Family Members Eligible for the Plan's Coverage?

Your **legal spouse** is eligible for coverage through the Welfare Fund. Your spouse will lose coverage on the day after a divorce or legal separation document is legally entered in a municipal institution.

Your children will be considered qualifying dependents and eligible for coverage through the Welfare Fund in accordance with the following:

A) the child has not reached beyond the end of the month of his/her 26th birthday.

B) unmarried children who have reached beyond the end of the month of his/her 26th birthday remain covered if they are incapable of self-support because of mental illness, developmental disability, mental retardation (as defined in the New York State mental hygiene law) or physical handicap provided the incapacitating condition started before the end of the month of his/her 26th birthday.

Please note: If your child is employed where employer-sponsored group coverage of a non-contributory nature is available, the Welfare Fund will provide secondary coverage only.

The term "children" includes:

- your biological or legally adopted children,
- children in your custody while awaiting final legal adoption,
- your stepchildren and
- any other children related to you by blood or marriage who live with you in a regular parent-child relationship and who are primarily dependent upon you for financial support who are eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively or and who will be claimed as a dependent on the your tax return for each plan year for which coverage is provided (an Affidavit of Dependency must be completed).

Excluded:

1) Parents and grandparents, even though they may reside in your household and be dependent upon you for support and maintenance, are **not** covered under the Plan.
2) No dependents of participants covered under the Helper classification are covered.

What Proof Do I Have to Provide for Dependent Status?

Specific documentation to substantiate dependent status will be required by the Plan. For each dependent, a copy of that dependent's social security card, along with the dependent specific items listed below, are **required** by the Plan to substantiate dependent status:

- **Spouse:** a copy of the certified marriage certificate.
- **Child:** a copy of the certified birth certificate showing biological child of employee.
- **Stepchild:** a copy of the birth certificate (showing your spouse as the biological parent of the child) plus the marriage certificate between you and the child's biological parent.
- **Adopted Child or Child Placed for Adoption:** a court order paper signed by the judge showing that the participant has adopted or intends to adopt the child, and a copy of the certified birth certificate.
- **Disabled Dependent Child:** a current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document), that disability existed before the attainment of the Plan's age limit, and that the child is incapable of self-sustaining employment as a result of that disability. In addition, the child must be chiefly dependent on you and/or your Spouse for support and maintenance. To continue coverage beyond age 26, an "Affidavit of Dependency for Mentally or Physically Handicapped Children", which includes proof of incapacitation from the dependent's physician or physicians, must be submitted to the Welfare Fund. Proof of incapacitation must be submitted to the Welfare Fund as often as requested. An independent examination must be permitted if the Trustees so requests. In addition, proof of dependent status from the Internal Revenue Service income tax filings must be made available to the Trustees as often as so requested. The affidavit must be filed with the Trustees prior to the date such a child attains age 26 in order to qualify for continuance of coverage.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by judge or National Medical Support Notice.

It is essential that any changes in family status (marriage, birth, death, adoption, divorce etc.) be reported in writing to the Fund Office. Failure to do so may delay or prevent payment of your claims.

What Happens to My Family's Health Coverage If I Die?

If you die while covered by the Fund, the health coverage for your spouse and qualifying non-spouse dependents will continue provided that you a.) earned a minimum of fifteen (15) years of credited service in the Steamfitters' Industry Pension Fund and worked for at least 15,000 hours in covered employment prior to your death or b.) you die while in military service.

Health coverage for your spouse and qualifying dependents will continue until:

1) your spouse remarries,

2) your non-spouse dependent reaches the end of the month of his or her 26th birthday, or

3) your mentally, developmentally, or physically handicapped dependent over age 26 is determined by the Trustees to no longer be incapable of self-support because of a mental, developmental, or physical incapacity.

If you die while covered in the Fund, but have not met the requirements listed above, the health coverage for your spouse and qualifying dependents will continue for three years calculated from the end of the month of your death. Coverage will terminate prior to three years upon the occurrence of (1), (2) or (3) listed above.

Health coverage for surviving spouses and qualified non-spouse dependents is provided in accordance with the Plan's applicable coordination of benefit regulations. Health coverage includes only hospital, medical, prescription drug, dental, vision care, and hearing aid benefits.

Do I need to Enroll in Benefits for Myself or My Dependents for Health Coverage?

You are automatically enrolled in benefits when you meet the eligibility requirements. However, for your dependents to be eligible you must enroll them for benefits**. You may enroll your dependents for coverage by submitting a completed written Insurance Census Information form to the Fund Office before coverage is effective.** The Insurance Census Information form may be obtained from the Fund Office. You may also enroll your dependents online by logging into your account on **www.steamfitters.com**.

Special Enrollment for a Newly Acquired Spouse and/or Dependent Child for Health Coverage

If you are enrolled for individual coverage and if you acquire a Spouse by marriage, or if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child(ren) provided you notify the Welfare Fund by completing an Insurance Census Information form. The Insurance Census Information form may be obtained from the Fund Office. You may also

enroll such dependents online by logging into your account on **www.steamfitters.com**. Coverage for your dependent will begin the first day of the month in which the Insurance Census Information form is received (or, in the case of a newborn Dependent Child, retroactive to the date of birth).

Proof of adoption or placement for adoption must be provided to the Welfare Fund. If you adopt a child, your adopted Dependent Child will be covered from the date that the child is "Placed for Adoption" with you. 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. Adopted newborns are covered from the moment of birth, provided that the child is placed for adoption with you no later than 31 days after the child is born and you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Special Enrollment for Loss of Coverage

- Special Enrollment for Individuals who lose coverage under Medicaid or a State Children's Health Insurance Program (CHIP): Effective April 1, 2009, if you did not enroll your dependent(s) in the Welfare Fund when first eligible, you may enroll your dependents if they have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage.

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at (212) 465-8888 or FundOffice@steamny.com.

CONTINUATION OF COVERAGE (COBRA)

If you lose coverage, you may be able to continue your coverage under the Plan. The Welfare Fund will charge those electing COBRA Continuation Coverage 102% of the Fund's cost of coverage. Please read this section carefully and contact the Fund Office if you have any questions or if you think you may be eligible.

This Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a person's COBRA rights.

Background Information

In 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group plans offer employees and their covered Dependents (called "Qualified Beneficiaries") the opportunity to elect to temporarily continue their group health care coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long?

Each Qualified Beneficiary has an **independent right** to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered participants may elect COBRA on behalf of their spouses and children. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Participant or the Spouse or Dependent Child of a participant who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

    - A child of a covered participant who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Participant's or retiree's period of coverage, is a Qualified Beneficiary.

2. "**Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and,** as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan.** If a covered individual has a Qualifying Event but,

as a result, **does not lose their health care coverage** under this Plan, (*e.g.* Participant continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Events and Maximum Periods of Continuation Coverage

Qualifying Event* Causing Welfare Fund Benefits to End	**Maximum Period of COBRA Continuation Coverage**		
	Participant	**Spouse**	**Dependent Child(ren)**
Participant is terminated (for reasons other than gross misconduct)	18 months	18 months	18 months
Participant experiences a reduction in hours worked (making Participant ineligible for the same coverage)	18 months	18 months	18 months
Participant Dies (while under COBRA Continuation Coverage)	N/A	36 months	36 months
Participant becomes Divorced or Legally Separated	N/A	36 months	36 months
Participant becomes Entitled to Medicare	N/A	36 months	36 months
Dependent Child loses Dependent Status	N/A	N/A	36 months

**To be considered a "Qualifying Event", the event must cause a loss of coverage under the Plan.*

When Must a Spouse or Dependent Child Notify the Plan of a Qualifying Event for Continuation of Coverage Purposes?

In order for a Spouse or Dependent Child to be entitled to COBRA Continuation Coverage, the Participant, Spouse, or Dependent Child must notify the Plan within 60 days of the date of the following:

- The death of the Participant;
- The divorce or legal separation from the Participant; or (Note: for purposes of preventing ineligible benefit usage the Fund Office must be notified immediately. Please refer to the Active Eligibility section of this booklet "What Happens If I Lose Coverage?" pages 11 and 12); or

- The event under which a Dependent Child loses Dependent status.

Notification must be made in writing to the Fund Office. You need to include the qualifying event, name of the Participant, name of Dependent, and the date of the qualifying event. You also need to provide the supporting documentation (for example, a copy of the Divorce Decree or Judgment or Death Certificate).

If the Plan does not receive written notice of any such event within that 60-day period, the Spouse and/or Dependent Child(ren) will not be eligible for COBRA Continuation Coverage. You must send this notice to the Fund Office.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA Continuation Coverage, the individual will be sent an explanation indicating why COBRA Continuation Coverage is not available. This notice of the unavailability of COBRA Continuation Coverage will be sent according to the same timeframe as a COBRA election notice.

How Will I be Informed if I or My Dependent(s) are Entitled to Continuation of Coverage?

The Plan will send you and your Dependents an Election Notice when a Qualifying Event occurs. The Election Notice will explain your right to continue health care coverage under the Plan. You and/or your Dependent(s) will then have 60 days to apply for COBRA Continuation Coverage. If you and/or they do not apply within that time, health care coverage will end as of the last day of the calendar quarter in which the Qualifying Event occurs.

What Coverage Will Be Provided if Continuation of Coverage is Elected?

If you and/or your Dependent(s) choose COBRA Continuation Coverage, the Plan is required to provide coverage that is identical to the current coverage under the medical and/or dental plan that is provided for similarly situated employees and their family members.

Addition of Newly Acquired Dependents

If during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that Spouse or Dependent Child may be enrolled in coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active employees. Enrollment must occur no later than 31 days after the marriage, birth or placement for adoption.

A child born or placed for adoption with you while you are on COBRA Continuation Coverage (but not a spouse that you marry while you are on COBRA Continuation

Coverage) will have all the same COBRA rights as your Spouse or Dependent Child(ren) who were covered by the Plan before the event that resulted in your loss of coverage. If you marry while on COBRA Continuation Coverage, your new spouse may be enrolled in coverage, but they will not be a Qualified Beneficiary. This means that if you die, divorce, or become eligible for Medicare during COBRA Continuation Coverage, your new spouse will not be permitted to elect COBRA for his/herself.

Otherwise, the same rules about Dependent status and qualifying changes in family status that apply to active Participants will apply to Dependent(s). Adding a spouse or a Dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. If during the period of COBRA Continuation Coverage, the Plan's benefits change for active participants, the same changes will apply to you and/or your Dependent(s).

Is an Extension of COBRA Continuation Coverage Period Due to Multiple Qualifying Events a Possibility?

If your COBRA Continuation Coverage is for a maximum period of 18 months, and during that period, another Qualifying Event takes place that would otherwise entitle a Spouse or Dependent Child to a 36-month period of COBRA Continuation Coverage, the 18-month period will be extended for that Spouse or Dependent Child. The total period of COBRA Continuation Coverage for any Spouse or Dependent Child will never exceed 36 months from the date of the first Qualifying Event. For example, if you terminated employment and elected COBRA Continuation Coverage for 18 months for you and your covered Spouse and/or Dependent Child(ren), and you died during that 18-month period, the COBRA Continuation Coverage for your Spouse and/or Dependent Child(ren) could be extended for the balance of 36 months from the date your employment terminated.

However, if you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours worked that occurred less than 18 months after the date you became entitled to Medicare, your Spouse and/or Dependent Child(ren) would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date you become entitled to Medicare, your Spouse and/or Dependent Child(ren) would be entitled to COBRA Continuation Coverage for a 36-month period beginning on the date you became entitled to Medicare, although your period of COBRA Continuation Coverage would be limited to 18 months from your termination.

What is the Maximum Period of COBRA Continuation Coverage?

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may

be extended for up to 11 months if one of the Qualifying Beneficiaries becomes disabled). The maximum period of COBRA Continuation Coverage may be cut short for the reasons described in the section on “Early Termination of COBRA Continuation Coverage” that appears later in this section.

Entitlement to Social Security Disability Income Benefits

If you, your Spouse of any of your covered Dependent Child(ren) are entitled to COBRA Continuation Coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security benefits, and for any other Qualifying Beneficiaries, for up to 11 additional months if all the following conditions are satisfied:

- The disability occurred on or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage; and
- The disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
- The Plan is notified by you or the disabled Qualifying Beneficiary that the determination was received:
    - No later than 60 days after it was received; and
    - Before the end of the 18-month COBRA Continuation Coverage period.
- This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the original Qualifying Event or the date the disabled individual becomes entitled to Medicare.

What is the Payment Amount for COBRA Continuation Coverage?

You, your covered Spouse and/or your covered Dependent Child(ren) will have to pay 102% of the full cost of the coverage during the COBRA Continuation Coverage period. However, any individual or family whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA Continuation Coverage.

The amount you, your covered Spouse and/or your covered Dependent Child(ren) must pay for COBRA Continuation Coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amount due starting with the date you elect COBRA Continuation Coverage. Payments are due on the first day of the month for which coverage is being continued. However, there is a grace period of 30 days to pay any subsequent payment. If payment of the amount due is not received by the end of the applicable grace period, COBRA Continuation Coverage will terminate, if:

- You, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage; and

- The amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect; and
- A Health Care Provider requests confirmation of coverage.

COBRA Continuation Coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation Coverage has not been paid and that COBRA Continuation Coverage will terminate, effective as of the due date of any unpaid amount if the payment of the amount due is not received by the end of the grace period.

Is Early Termination of COBRA Continuation Coverage Possible?

COBRA Continuation Coverage may be cut short (terminated early) if:

- The Plan no longer provides group health coverage to any of its similarly situated employees;
- You do not pay the applicable premium for your COBRA Continuation Coverage on time;
- The Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA Continuation Coverage;
- The employer that employed you before the Qualifying Event stops contributing to the Plan and either establishes another group health plan or contributes to another multiemployer health plan; or
- The Qualified Beneficiary becomes covered under another group health plan.

If any Qualified Beneficiary becomes entitled to Medicare, the COBRA Continuation Coverage of that person will end, but the COBRA Continuation Coverage of any covered Spouse or Dependent Child of that covered person will not be affected.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary of early termination of COBRA Continuation Coverage. This written notice will explain the reason for early termination of COBRA Continuation Coverage, the date coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Welfare Fund determines that COBRA Continuation Coverage will terminate early.

Other Information about COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone who has

elected COBRA Continuation Coverage. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA, as of the effective date of those changes.

What are the Special Enrollment Rights?

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or, under certain circumstances, 60 days) after your group health coverage ends because of the Qualifying Events listed in this section. The special enrollment right is also available to you at the end of the maximum period of COBRA Continuation Coverage.

Is a Participant or Dependent Entitled to Convert to an Individual Health Plan after COBRA Ends?

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan. You may have other options available to you. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. For more information about the Marketplace, visit: www.HealthCare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation of Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA Continuation Coverage instead, you may have to pay a Part B lifetime late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA Continuation Coverage and then enroll in Medicare Part A or B before the COBRA Continuation Coverage ends, the Plan may terminate your Continuation Coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA Continuation Coverage

may not be discontinued based on Medicare eligibility, even if you enroll in the other part of Medicare after the date of the election of COBRA Continuation Coverage.

If you are enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA Continuation Coverage will pay second. Certain COBRA Continuation Coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

HOSPITAL AND MEDICAL BENEFITS

These benefits are administered through insurance contracts with Empire BlueCross BlueShield.

Active and Retired Non-Medicare Eligible Participants and Dependents

Hospital and Medical Benefits are provided under an EPO Plan (an Exclusive Provider Organization). EPOs will only cover medical expenses if the provider you utilize is part of the network of providers covered by the plan. Partial reimbursement may be allowed for emergency cases outside the network.

A full and complete description of the hospital and medical benefits available are contained in the blue-colored pages of this booklet. You should pay particular attention to information about exclusions and limitations, Medical Management, and precertification requirements.

Retired Medicare Eligible Participants and Dependents

Hospital, Medical and Prescription Drug Benefits are provided by Empire MediBlue Freedom PPO Plan for all retired Medicare eligible members or dependents who are covered under the Welfare Fund's retiree coverage.

The Empire MediBlue Freedom PPO Plan is a Preferred Provider Organization. You have the freedom to choose any provider you want inside or outside your plan's network when you use providers that accept Medicare. A full and complete description of all benefits available under the MediBlue program (a Medicare Advantage plan) is mailed individually to each participant and dependent annually by Empire BlueCross BlueShield pursuant to federal law. This detailed description is called an "Evidence of Coverage" booklet.

PRESCRIPTION DRUG BENEFITS

Who Administers the Benefits?

Prescription drug benefits are available to all non-Medicare participants and their qualifying dependents who meet the Welfare Fund eligibility requirements. Your prescription drug benefits are administered by **Express Scripts, Inc.** which covers almost all drugs prescribed by a licensed medical doctor, osteopath, dentist or podiatrist for their generally accepted medical use.

This benefit includes both a Retail Program and a Home Delivery/Mail Service Program. This benefit program was instituted to increase benefits, alleviate the claim filing burden and reduce costs when you or your eligible dependents require prescription drugs. At the time your coverage becomes effective you may receive an identification drug card and home delivery/mail service order forms.

What are the General Types of Prescription Drugs?

There are three types of Prescription Drugs:

- Generic
- Brand
- Specialty**

All Prescriptions have a Co-Payment associated with them except for those prescriptions that are considered “preventative” under the Patient Protection and Affordable Care Act. (PPACA).

**The Trustees of the Steamfitters Welfare Fund, in an effort to alleviate the costs of certain specialty drugs, approved the participation in the Express Scripts SaveonSP program. This program identifies certain high cost specialty drugs that are eligible for copayment assistance through the drug manufacturer. Should you be taking any prescription that is considered “qualifying”, you will be contacted by SaveonSP to participate. Should you choose to participate, you will have no out of pocket costs for the drug.

How Does the Prescription Drug Benefit Program Work?

The Prescription Drug Benefit works through the following three components: The Retail Program, the Home Delivery/Mail Service Program and a Direct Reimbursement Program. These components are further explained in this section.

Both retail and mail order prescriptions must be filled with generic drugs if a generic equivalent is available. If you have a prescription filled with a brand name drug

when a generic is available ***for any reason*** you will pay the brand name co-payment plus the difference between the cost to the Welfare Fund for the generic and the brand. ***Using a brand name drug when a generic is available may cost you a great deal of out-of-pocket expense.***

❖ RETAIL PROGRAM

Whenever you need to fill a prescription at a local pharmacy all you will have to do is present your Express Scripts identification card to a network pharmacy and make a small co-payment. The co-payments for each prescription will be $10.00 for generic drugs, $30.00 for brand name drugs and $43.00 for controlled substances. You can receive up to a 21-day supply of your medication and ***one*** refill only for the same number of days. Beyond that, you ***must*** use the Home Delivery/Mail Service Program.

A 30-day fill will be permitted for controlled substances only. Although there is no limit in terms of refills for controlled substances, the law requires a prescription for each reorder.

Under the Retail Program, the Walgreen Co. retail pharmacies (Walgreen's, Duane Reade, et al.) are not covered as they are not in the retail pharmacy network we contracted with Express Scripts, Inc. Visit express-scripts.com to find a participating retail pharmacy.

❖ HOME DELIVERY/MAIL SERVICE PROGRAM

If you or any of your dependents need medication on an on-going basis (maintenance drugs), you ***must*** fill those prescriptions through the Home Delivery/Mail Service Program, commonly called *Express Scripts, Inc. By Mail*. Prescriptions filled through the Home Delivery/Mail Service Program are subject to individual participant and dependent co-payment of $40. The drugs are delivered to your home, postage paid. Your physician can prescribe up to a 90-day supply with refills of the medication you need.

You will then submit your prescription and claim form to the home delivery/mail service pharmacy for dispensing. If you require a refill, just notify the home delivery/mail service pharmacy by mail, by phone (800) 445-9707, or online at express-scripts.com.

No claim forms are required for prescriptions obtained through the Retail or Home Delivery/Mail Service Program.

❖ DIRECT REIMBURSEMENT PROGRAM

Should there arise an occasion that you are unable to use the Retail Program or Home Delivery/Mail Service Program, a *direct reimbursement claim* process has been established between the Welfare Fund and Express Scripts, Inc. ***This program may reimburse you significantly less than the amount you paid for the prescription.*** Participants are permitted to use the Direct Reimbursement Claim procedure only once during their lifetime coverage for a reason deemed valid by the Fund. Under no circumstances will you be reimbursed for a prescription purchased at a Walgreen Company pharmacy.

Contact the Fund Office at (212) 465-8888, option 4 to obtain a Direct Reimbursement Claim form. The claim form must be filled out by the patient as well as the pharmacist and returned to the Fund Office. Along with the complete claim form, you must submit a letter to the Fund Office explaining why you were unable to use the Retail Program or the Home Delivery/Mail Service Program. Upon approval by the Fund, your claim will be submitted to Express Scripts, Inc. for processing.

❖ THE EXPRESS SCRIPTS MOBILE APP

The Express Scripts mobile app helps you stay on track with taking your medications as prescribed and help with prescription refills and renewals, safety alerts, reminder, and potential savings. The app also offers a feature to use your phone to display a virtual card that you can show at the pharmacy. The app is called “Express Scripts” and is compatible with all mobile devices. Download it for free today from the App Store or on Google Play. After downloading the app, log in with your express-scripts.com user ID and password to open. Iif you haven’t yet registered on express-scripts.com, please go to the site to get your Express Scripts user ID and password.

What Prescription Drugs Are Covered in This Program?

Both retail and mail order prescriptions must be filled with a generic drug if a generic equivalent drug is available. Prescription drugs available under both the Retail Program and the Home Delivery/Mail Service Programs include:

- Federal Legend Drugs that are included in the National Preferred Formulary*
- State Restricted Drugs
- Compounded Medications
- Insulin and insulin syringes only
- Narcotic painkillers (considered controlled substances)
- Certain OTC items pursuant to the ACA

Each state establishes its own legal list of controlled substances. Typically, under state laws, a controlled substance cannot have more than a 30-day fill.

The National Preferred Formulary is a list of the most commonly prescribed drugs that are covered under the prescription plan. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

Are There Any Exclusions in This Program?

The following are the excluded items to the prescription plan:

- Non-Federal Legend Drugs including certain "over the counter" items, regardless of whether they are prescribed.
- All gene therapy drugs.
- Charges for the administration or injection of any drug.
- Needles and syringes, support garments, and other non-medical substances (such items may be covered under your medical benefits coverage).
- Prescriptions which you are entitled to receive without charge under any Workers' Compensation Laws or any municipal, state or federal program.
- Medication taken by, or administered to, a person while an inpatient in a licensed hospital, hospice, rest home, sanitarium, extended care facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceutical products.
- Drugs labeled "Caution - limited by federal use to investigational use" or experimental drugs.
- Blood, blood plasma or biological sera.
- Vitamins; except those, which by law, require a prescription.
- Any prescription filled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

What Programs Have Been Instituted to Ensure Proper Drug Use?

The Welfare Fund is committed to providing quality prescription drug benefits. With this goal in mind, we use a set of Utilization Management Programs (UM), administered by Express Scripts, Inc. to determine how your prescription drug plan will cover certain medications. The goal of these programs is to alleviate inappropriate and potentially harmful use of prescription drugs while simultaneously assuring the proper utilization of

benefit dollars. Member health, safety, and satisfaction remain the primary objectives of the prescription drug coverage. In addition to the UM programs, the Welfare Fund is also enrolled in “SafeguardRX”; a value-based set of programs to prevent and guard the Fund against unnecessary and prohibitive drug price increases.

The UM programs are Coverage Review, Step Therapy, Preferred Step Therapy, Quantity Duration and Retrospective Drug Utilization Review Health and Safety Program along with a Fraud, Waste & Abuse Program. These programs are defined below:

Coverage Review (Prior Authorization Required)

For some medications, you must obtain prior approval through a review process in order to obtain coverage. When you use Express Scripts By Mail, Express Scripts will call your doctor to start the coverage review. If you submit a prescription to a participating retail pharmacy for a medication that requires coverage review, you, your doctor, or your pharmacist can initiate the review by calling (800) 753-2851.

If coverage is not approved, either at a retail or mail-order basis, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request the appeal will be included in the letter that you receive.

Step Therapy

Step Therapy looks at a patient’s prescription history and determines whether he or she is eligible for a given medication without a coverage review. If there is not enough information in the history, a coverage review may be necessary.

Preferred Step Therapy

The Preferred Step Therapy program manages our prescription-drug waste within specific therapy classes by guiding patients to frontline medications before “stepping up” to more costly backup medications.

Within specific therapy classes, several clinically effective medications are often available to treat the same condition. This program takes advantage of these opportunities by utilizing clinically effective, lower-cost medications. Evidence-based clinical protocols for each step therapy module ensure patients receive cost-effective drug therapy that is clinically appropriate for their condition.

Quantity Duration

Your prescription drug plan provides coverage for a quantity of medication and duration of treatment sufficient to meet the needs of most patients. If a greater quantity or longer course of treatment is needed, a coverage review process is required.

Quantity Duration – No Review

Your plan will cover 6 pills of the medications listed below within a 21-day period. Prescriptions that exceed that amount will not be covered by the plan. Your retail

pharmacist or your mail-order pharmacy may reduce the quantity of medication dispensed to an amount covered by your plan. If you choose to obtain additional quantities, you will be responsible for the full cost of the medication at your retail pharmacy.

Retrospective Drug Utilization Review Health and Safety Program

Express Scripts may provide information to your doctor about potential prescribing or medication utilization issues. These include situations in which similar and overlapping medications appear to have been prescribed for the same condition, or when medications may interact with each other in a way that could be harmful to your health.

The information we provide to your doctor is intended to help ensure that you get the safest and most effective therapy possible, especially when more than one doctor is involved in your care. A change in your prescription(s) can sometimes result from these communications between Express Scripts and your doctor.

Fraud, Waste & Abuse

The Fraud, Waste & Abuse Program is designed as a preventative, cost saving measure to identify and eliminate instances of “doctor or pharmacy shopping” as well as detecting duplicate therapies, stockpiling, fraud, overprescribing as well as other costly and detrimental practices.

Pharmacy Vaccination Program

The Steamfitters Welfare Fund encourages all its members to take advantage of the Pharmacy Vaccination program. To assist you and your families to stay healthy, you can now receive vaccines directly at your local participating retail pharmacy through the Welfare Funds prescription drug benefit through Express Scripts. Some of the vaccines include Flu, Childhood Vaccines, HPV, Meningitis, Pneumonia, Shingles, Tetanus, Travel Vaccines and others.

Before you visit the pharmacy, it is your responsibility to ensure that the pharmacy is part of the Express Scripts pharmacy network. You can look up a specific pharmacy on the Express Scripts website, express-scripts.com. Call the pharmacy to verify their vaccination schedule, availability and any restrictions. Remember that the Walgreen Co. retail pharmacies (Walgreen’s, Duane Reade, et al.) are not in the retail pharmacy network we contracted with Express Scripts, Inc

It is your responsibility to ensure the vaccine is administered by the pharmacist and **NOT** an onsite clinic.

DENTAL EXPENSE BENEFITS

METLIFE PREFERRED DENTIST PROGRAM (PDP PLUS)

The following benefits are provided to all eligible Welfare Fund participants and their qualifying dependents subject to the provisions of the program. The Dental Plan is administered by MetLife.

SCHEDULE OF BENEFITS

DENTAL EXPENSE BENEFITS

DEDUCTIBLE AMOUNT
For Services of Network Providers……None

For Services of Non-Network Providers
Type A, B, C and/or D Expenses Combined
Individual ……$100
Family ……$200

COVERED PERCENTAGE
For Services of Network Providers
Type A Expenses……100%
Type B Expenses……100%
Type C Expenses……100%
Type D Expenses…… 75%

For Services of Non-Network Providers
Type A Expenses…… 80%
Type B Expenses…… 80%
Type C Expenses…… 60%
Type D Expenses…… 50%

[When a Non-Network Provider is used, the covered expenses schedule is based on the MetLife PDP network schedule of benefits.]

MAXIMUM
For Orthodontic Treatment
Aggregate Maximum Benefit
Lifetime per covered Dependent Child……$4,000

For Other Covered Dental Expenses
Maximum Benefit
Per Calendar year per Covered Individual……$4,000

PLEASE NOTE:

- Expenses for orthodontia, including any procedures necessary for such treatment, will be considered covered dental expenses only for a Dependent Child until the end of the month of his or her 26th birthday.
- Covered dental expenses for orthodontia are not included in the Maximum Benefit per calendar year.
- The maximums for both orthodontic treatment and all other covered dental expenses apply to all expenses incurred whether treatment is provided by a Network Provider, a Non-Network Provider or a combination thereof.
- If a dental bill is expected to be $300 or more, see section F, Predetermination of Benefits.

DENTAL EXPENSE BENEFITS

A. DEFINITIONS

Covered Dental Expense means the charges based on the Preferred Dentist Program Schedule of Maximum Payments for the types of dental services shown in section C. These services must be:

1. performed or prescribed by a dentist who is:
    - a Network Provider; or
    - a Non-Network Provider; and
2. necessary in terms of generally accepted dental standards.

There may be more than one way to treat a dental problem. If, in MetLife's view, an adequate method or material which costs less could have been used, the dental expense benefits will be based on the method or material which costs less. The balance of the cost will not be a covered dental expense. See section E for examples that show how this works.

Covered Percentage means the percentage shown in the Schedule of Benefits.

Dentist means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a doctor will be considered for dental expense benefits as if it were performed or prescribed by a dentist.

Deductible Amount means the amount shown in the Schedule of Benefits for non-network. The deductible amount during any one calendar year will not apply to covered non-network dental expenses after:

1. you incur covered dental expenses for covered persons in your family; and
2. those expenses, when applied to the deductible amount, equal the family deductible amount.

Network Provider means a dentist who has been selected by MetLife for inclusion in the Preferred Dentist Program. These Network Providers agree to accept the Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

Non-Network Provider means a dentist who is not a Network Provider.

Preferred Dentist Program means MetLife's program to offer a covered person the opportunity to receive dental care from dentists who are designated by MetLife as Network Providers. When dental care is given by Network Providers, the covered person will generally incur less out-of-pocket cost for the services rendered.

Preferred Dentist Program Directory means the list which consists of selected dentists who:

- are located in the covered person's area; and
- have been selected by MetLife to be Network Providers and part of the Preferred Dentist Program. These Network Providers agree to accept our Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

Preferred Dentist Program Schedule of Maximum Payments means MetLife's fee agreement with a Network Provider in which such Network Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

B. COVERAGE

1. When Benefits May Be Payable

MetLife will pay dental expense benefits if you incur covered dental expenses:

- for a covered person during any calendar year; and
- while the person is covered for the dental expense benefits; and
- to the extent that the covered dental expenses for Non-Network Providers are more than the deductible amount

An expense is “incurred” on the date the dental service complete.

2. How Benefits Are Determined

Benefits will be equal to the covered percentage of those covered dental expenses (in the case of Non-Network Provider services, and which are more than the deductible amount). However:

- The sum of all benefits for all covered dental expenses incurred for a covered person during any calendar year will not be more than the Maximum Benefit per calendar year; and

- The sum of all benefits for all covered dental expenses incurred for a covered person for orthodontic treatment during the covered person's lifetime will not be more than the applicable Aggregate Maximum Benefit.

In order to determine the amounts of covered dental expenses, MetLife may ask for x-rays and other diagnostic and evaluative materials. If they are not submitted, MetLife will determine covered dental expenses based on the information which is available. This may reduce the amount of benefits which otherwise would have been payable.

3. How the Preferred Dentist Program Works

You will generally incur less out-of-pocket cost if you use a Network Provider. Services by Non-Network Providers will be covered, but your coverage will be less and you will be required to pay a deductible.

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

1. Type A Expenses

a. Oral exams but not more than twice in any calendar year and no less than 180 days apart.

b. X-rays:
   - full mouth x-rays but not more than once every 36 months.
   - bitewing x-rays but not more than twice in any calendar year (every 183 days).

c. Preventative Treatment
   - cleaning and scaling of teeth (oral prophylaxis) but not more than twice in any calendar year; and
   - topical fluoride treatment for a Dependent Child who has not reached the end of the month of his or her 26th birthday, but not more than twice in any calendar year.

d. Space maintainers for a Dependent Child until the end of the month of his or her 26th birthday.

e. Two applications of sealant material for each molar tooth of a Dependent Child under age 16 not more than twice in a lifetime.

f. Emergency palliative treatment.

2. Type B Expenses

a. Fillings - amalgam, silicate, acrylic, synthetic porcelain or composite fillings.

b. Extractions

c. Root canal treatment

d. Treatment of periodontal disease and other diseases of the gums and tissues of the mouth.

e. Oral surgery

f. Injections of antibiotic drugs

g. Administration of general anesthesia, when medically necessary in connection with oral surgery, extractions, or other covered dental services.

h. Relining and rebasing of existing removable dentures, but not more than once in any 36-month period.

i. Repair or re-cementing of crowns; inlays or onlays; dentures; or bridgework.

3. Type C Expenses

a. Those services needed to replace one or more natural teeth which are lost while dental expense benefits for the covered person are in effect for:

- Installation of fixed bridgework done for the first time.
- Installation for the first time of a partial removable denture or a full removable denture.

b. Replacing an existing removable denture or fixed bridgework if it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed or it is needed because the existing denture or bridgework can no longer be used and the existing denture or fixed bridgework was installed at least 60 months prior to its replacement.

c. Replacing an existing immediate temporary full denture by a new permanent full denture when the existing denture cannot be made permanent, and the permanent denture is installed within 12 months after the existing denture was installed.

d. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

e. Inlays, onlays, and crown restorations, but not more than one such restoration to the same tooth surface within 60 months of the prior restoration.

f. Implantology.

4. Type D Expenses

Orthodontia, including appliance therapy for Dependent Children until the end of the month of his or her 26th birthday. The Aggregate Maximum Benefit for orthodontia during a Dependent Child's lifetime is shown in the Schedule of Benefits.

D. EXCLUSIONS: SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

1. Services or supplies received by a covered person before the dental expense benefits start for that person.
2. Services not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist, and which are for:
    - cleaning and scaling of teeth; or
    - fluoride treatments.
3. Cosmetic surgery or supplies. However, surgery or supply will be covered IF:
    - it otherwise is a covered dental expense; and
    - it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
    - it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent Child which has resulted in a functional defect.
4. Replacement of a lost, missing or stolen crown, bridge or denture.
5. Repair or replacement of an orthodontic appliance.
6. Services or supplies which are covered by any Workers' Compensation Laws or occupational disease laws.
7. Services or supplies which are covered by any employers' liability laws.
8. Services or supplies which any employer is required by law to furnish in whole or in part.
9. Services or supplies received through a medical department or similar facility which is maintained by the covered person's employer.
10. Services or supplies received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person.
11. Services or supplies for which a covered person is not required to pay.
12. Services or supplies which are deemed experimental in terms of generally accepted dental standards.
13. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect.

14. Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
15. Any duplicate appliance or prosthetic device.
16. Use of materials to prevent decay other than fluorides and sealant material for the molar teeth of a Dependent Child under age 16.
17. Instruction for oral care such as hygiene or diet.
18. Periodontal splinting.
19. Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan which the employer (or an affiliate) contributes to or sponsors.
20. Myofunctional therapy or correction of harmful habits.
21. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the dental expense benefits started for the covered person (adults only).
22. Charges for broken appointments.
23. Charges by the dentist for completing dental forms.
24. Sterilization supplies.
25. Services or supplies furnished by a family member.
26. Treatment of temporomandibular joint disorders.

Coverage for Dental Expenses will be based on the materials and method of treatment which cost the least, and which meet generally accepted dental standards.

E. EXAMPLES OF ALTERNATE BENEFITS

1. **Fillings: Inlays, Onlays and Crowns**

   If a tooth can be repaired by a less costly method than an inlay, onlay or crown, dental expense benefits will be based on the adequate method of repair which costs the least.

2. **Crowns, Pontics, and Abutments**

   Veneer materials may be used for front teeth or bicuspids. However, dental expense benefits will be based on the adequate veneer materials which cost the least.

3. **Bridgework and Dentures**

   Dental expense benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental expense benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your dental expense benefits will be, see section F.

F. PREDETERMINATION OF BENEFITS

If a dental bill is expected to be $300 or more, before the dentist starts the treatment, you and your dentist should submit a pre-treatment estimate outlining the treatment plan and related charges. This way, you will know what services MetLife will cover and at what payment level. Services that usually require a pretreatment estimate include crown, bridges, inlays, onlays and periodontics. To do this, send a claim form to MetLife in which the dentist states:

1. the work to be done; and
2. what the cost will be.

MetLife will then tell you what the dental expense benefits schedule is. The predetermination does not review eligibility for services which have time limitations, for example, dentures cannot be replaced within 5 years of installation. If you do not use this method to find out what dental expense benefits MetLife will pay, the decision will be final and binding regarding what are covered dental expenses and what dental expense benefits will be paid.

This method should not be used for:

- emergency treatment; or
- routine oral exams; or
- x-rays, cleaning and scaling, and fluoride treatments: or
- dental services which cost less than $300.

G. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

To the extent that services or supplies, or benefits for them, are available under a government plan, as defined below, they will not be considered for dental expense benefits under this benefit program. This provision will apply whether or not you are enrolled for all government benefits for which you are eligible. This provision will not apply to a government plan if it requires that dental expense benefits under this benefit program be paid first.

A government plan is any plan, program or coverage, other than Medicare:

- which is established under the laws or the regulations of any government; or
- in which any government participates other than as an employer.

H. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

No benefits will be payable for covered dental expenses incurred by a covered person after the dental expense benefits for that person end. This will apply even if we have pre-determined benefits for dental services. However, benefits for covered dental expenses incurred for a covered person for the following services will be paid after dental expense benefits end:

1. For a prosthetic device if:
    - the dentist prepared the abutment teeth and made impressions while dental expense benefits for the covered person were in effect; and
    - the device is installed within 60 days after the date the dental expense benefits end; or

2. For a crown if:
    - the dentist prepared the tooth for the crown while the dental expense benefits for the covered person were in effect; and
    - the crown is installed within 60 days after the date the dental expense benefits end; or

3. For root canal therapy if:
    - the dentist opened the tooth while the dental expense benefits for the covered person were in effect; and
    - the treatment is finished within 60 days after the date the dental expense benefits end.

I. PAYMENT OF BENEFITS

MetLife will send payment directly to your Network Provider. When a Non-Network Provider is used, dental expense benefits will be paid to you and you are responsible for paying the provider. MetLife will pay benefits when it receives satisfactory written proof of your claim. Proof must be submitted not later than 90 days after the end of the calendar year in which the covered dental expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the proof is given as soon as possible.

WHEN BENEFITS END

- All your benefits will end on the date your coverage in the Welfare Fund ends. Your coverage ends when you fail to maintain eligibility. Please refer to the **ACTIVE ELIGIBILITY** section for details.
- If this benefit program ends in whole or in part, your benefits which are affected will end.
- All benefits on account of a qualifying dependent will end on the last day of the calendar year in which that qualifying dependent ceases to qualify for dependent coverage under the Welfare Fund.

The end of any type of benefits on account of a covered person will not affect a claim which is incurred before those benefits ended.

The dental expense benefits for a covered person may be continued in accordance with the federal law called COBRA. Please refer to the answer to the question ***"What Happens If I Lose Coverage**?"* under the **ACTIVE ELIGIBILITY** section of this booklet for details.

Dental care benefits are considered “excepted benefits” and are not subject to the Patient Protection and Affordable Care Act provisions such as the essential health benefits mandate. You can reject coverage for dental care benefits if you choose to. Please contact the Fund Office for information regarding rejecting this coverage.

VISION CARE BENEFITS

What vision care benefits does the plan offer?

Vision care benefits are available for you and your qualifying dependents. This benefit will reimburse you for the cost of eye examinations, frames, and/or lenses, including contact lenses and prescription sunglasses. Non-prescription sunglasses are excluded from this program.

Vision care benefits are available in the maximum amount of $300 per covered individual each calendar year. You must be covered under the Welfare Fund on the date of service or the purchase date. In addition, the date of service or the purchase date will determine whether you have reached the maximum benefit for the year. Claims must be filed within a twelve-month period following the date services were provided. Failure to file proof of claims within the required time period shall result in a forfeiture of benefits.

Any unpaid balance of your or your qualifying dependents' vision care purchase may be submitted to the Health Reimbursement Account Fund provided you have a sufficient account balance in that Fund. Please call the Fund Office at (212) 465-8888, option 8 if you have any questions regarding this matter.

Vision care benefits are considered "excepted benefits" and are not subject to the Patient Protection and Affordable Care Act provisions such as the essential health benefits mandate. You can reject coverage for vision care benefits if you choose to. Please contact the Fund Office for information regarding rejecting this coverage.

HEARING AID BENEFITS

This benefit is available solely as a reimbursement towards the cost of purchasing a hearing aid. It is available to you and your qualifying dependents. Hearing aid benefits cannot exceed $2,000 per covered individual during any calendar year. The purchase date of the hearing aid is the applicable date for reimbursement, not the date you file the form. You must be covered in the Welfare Fund on the purchase date. This benefit cannot be used for the cost of repairs or for batteries.

All applications for the hearing aid benefits must be accompanied by an itemized bill and a letter of medical necessity written by a healthcare professional. This healthcare professional must be a Doctor of Medicine (MD), Doctor of Audiology (AuD), or have a certificate of Clinical Competence (American Speech-Language-Hearing Association Certification) (CCC-A)). The letter must be specifically addressed to the Trustees of the Welfare Fund and must state the patient's name, the date they were evaluated and the diagnosis.

Any unpaid balance for you or your qualifying dependents hearing aid purchase must be submitted to the Health Reimbursement Account provided you have a sufficient balance. Please call the Fund Office at (212) 465-8888, option 8 if you have any questions regarding this matter.

MEDICARE ADVANTAGE

GENERAL BACKGROUND

Medicare, the federal health program provided for people 65 years and older or to those who are to receive or receiving a Social Security Administration (SSA) Disability Award, has two kinds of health insurance. Part A, the hospital insurance, helps you with the cost of hospitalization and related care; and Part B, the medical insurance, helps pay doctor bills and other health expenses. Medicare Part D provides outpatient prescription drug benefits.

It is required that each retiree covered by the Welfare Fund contact their local Social Security Administration office at least three months prior to their 65th birthday for information about Medicare benefits and enrollment requirements. If you are still working and you are over age 65, you should contact the Social Security Administration office before you plan to retire. You must enroll in Part A and Part B. Your Medicare eligibility commences the first of the month in which you will turn age 65 or the first day of the month after you have been receiving a Social Security Disability Award for a period of 24 months. You will be enrolled in the Empire BlueCross BlueShield MediBlue Freedom PPO Plan (a Medicare Advantage program that includes prescription drug coverage).

When either you or your spouse receives your Health Insurance (Medicare) Identification card, check it carefully to see that all your personal information is recorded correctly. Also verify that at the bottom of the card coverage is indicated for both hospital insurance and medical insurance and that an effective date is indicated for each type of coverage. The Welfare Fund requires that you mail us a copy of your Medicare Card which displays both your Part A and Part B effective dates for the Welfare Fund Office to complete your enrollment in the MediBlue Freedom PPO Plan.

Please also be advised if you have not enrolled in Medicare Part A and Part B as of the first day of your eligibility due to age or because of a Social Security Award or you choose, by omission or commission, at your initial enrollment date or anytime thereafter not to “enroll in” the MediBlue Freedom PPO Plan you will lose all entitlement to hospital, medical benefits and prescription drug benefits in perpetuity, i.e., forevermore, under the Welfare Fund. However, you retain coverage for Vision, Hearing and Dental Benefits.

In addition, if you do not submit a copy of your Medicare card within thirty (30) days of your eligibility effective date, you will not be enrolled in the Empire MediBlue Freedom PPO Plan and your coverage under the Welfare Fund will terminate.

Lastly, please be aware that Medicare Part B & Part D premiums are based on your income two years prior to your Medicare effective date. Generally, you are responsible for 25% of the Medicare Part B premium, but you will pay a greater percentage of the Medicare Part B premium if you report Modified Adjusted Gross Income above $91,000 in 2022 ($182,000 if you file married filing jointly). You may also pay more for your Medicare Part D coverage.

ADDITIONAL INFORMATION

- If you are enrolled in the Empire MediBlue Freedom Plan PPO, our Medicare Advantage plan, but become employed in our industry and qualify for coverage under the regular Active Eligibility rules (refer to pages 9-16), your coverage and those of your dependents will be primary with the Welfare Fund, not the MediBlue Plan. This is in accordance with Medicare's Secondary Payer rules for large health care groups. Please contact the Fund Office if you have any questions pertaining to employment after an initial enrollment in the MediBlue Plan.

- If you are Medicare eligible but can retain group coverage either through your own active employment or as a dependent under your Spouse's group plan, it may not be to your advantage to enroll in Medicare since it will not duplicate your group benefits.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a provision in group health and group dental contracts, where applicable, that prevent duplicate payments for the same covered medical or dental expenses. The COB provision applies only when a participant or eligible dependent is covered under more than one group health or dental program. When that is the case, the Welfare Fund will coordinate benefit payments with the other group plan. One group will pay its full benefit as the primary plan and the other group will pay secondary benefits (if necessary) to cover some or all the remaining expenses. This COB provision prevents duplicate payments and overpayments. In no case should the benefits received from the two group plans in total be greater than the medical or dental allowed charges.

The rules to determine the order of payment under Welfare Fund coverage in those cases where there is coverage under more than one group plan are as follows:

A) If the other group plan does not have a COB provision similar to the Welfare Fund's, then that group will be primary.

B) If both groups have a COB provision, the group covering the person as a participant is primary.

C) If a Dependent Child is covered under both parents' group plan and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. For purposes of determining the earlier birthday only the month and day are considered; the year of birth has no significance. If both parents have the same birthday, the plan which covered the parent longer will be primary. However, if the other group plan does not use the "birthday rule," but instead uses a rule based on the gender of the parent and as a result the two plans do not agree on which is primary, then the father's group plan shall be primary.

D) If a Dependent Child is covered under both parents' group plan, the parents are separated or divorced, and there is no court decree which establishes financial responsibility for the child's coverage, the plan of the parent who has custody (the custodial parent) shall be primary. However, if the custodial parent has remarried and the child is also covered as a dependent under the stepparent’s plan, the custodial parent's plan will pay first, the stepparent’s plan second and the non-custodial parent's plan third.

E) If a court decree specifies which parent is to be responsible for the child's coverage and that parent's plan has actual knowledge of the decree, then that parent's plan will be primary.

F) If a person is covered under one group as an active participant or as the dependent of an active participant and is also covered under another group as a retired participant or as the dependent of a retired participant, the group which covers that person as an active participant or as the dependent of an active participant is primary. If the other group plan does not have this rule, and as a result the two plans do not agree on which is primary, then this rule will be ignored.

G) If none of the above rules determine which group plan is primary, the group plan covering the person for the longer period is primary.

Coordination of Benefits with Medicare

If you or your spouse are age 65 or older, you may be eligible for benefits under Medicare. You do not have to be retired to receive these benefits. Medicare includes hospital insurance benefits ("Part A"), as well as supplementary medical insurance ("Part B").

If you remain eligible for coverage under the Plan due to your current Employment status with an Employer, regardless of your age, you will receive the same benefits from the Plan as a Participant under age 65. Likewise, if a claim is incurred by an eligible Dependent covered by Medicare while you maintain eligibility because you are currently employed by an Employer, the Plan is primary and Medicare is secondary. Medicare will provide secondary coverage for some care if the Plan does not pay the full cost.

Coordination of Benefits with Medicaid

For purposes of coordinating benefits with Medicaid, the Plan will assume primary payer status for any Participant or alternate recipient who is entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to a Participant or alternate recipient will be made in accordance with any assignment of rights made by or on behalf of such Participant or alternate recipient as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If the Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Participant or alternate recipient for payment of such benefits. The provisions of Section 1908 of the Social Security Act apply to the extent such provisions are in accordance with state Medicaid law.

Coordination of Benefits with TRICARE

If an eligible Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and

the Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Who Provides Our Term Life Insurance Benefits?

MetLife provides group term life insurance benefits for any active covered participant who is eligible for coverage under the Welfare Fund. If you are an active covered participant and you die from any cause, your designated beneficiary will be paid $50,000. Proof of death must be provided within 90 days of loss.

When the Fund Office forwards your claim to MetLife, MetLife will review the claim, and if they approve it, they will pay the Beneficiary the Life Insurance in effect on the date of death. Further details may be found in “Your Benefit Plan” provided to you by MetLife.

Please call the Fund Office at (212) 465-8888, option 4 for further details and to obtain the required claim forms. If notice of claim or proof is not given within the time limits, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible.

Are there Life Insurance Payment Options?

Your beneficiary may receive life insurance proceeds from MetLife in one of two ways:

- A single lump-sum check or
- Proceeds can be deposited into a MetLife sponsored and guaranteed “checking” account called a Total Control Account whereby your beneficiary can access proceeds at his or her discretion.

Does Our Life Insurance Include an Accelerated Benefit Option?

Yes, if you should become terminally ill while covered under the Welfare Fund for Life Insurance, you or your legal representative may request that MetLife pay an Accelerated Benefit Option (herein called ABO). A terminal illness diagnosis due to injury or sickness requires that the life expectancy must be no longer than 12 months. *The Accelerated Benefit Option request must be made while ABO Eligible Life Insurance is in effect.*

Upon MetLife approval of any ABO, they will pay you up to $40,000 (80% of the life benefit of $50,000). MetLife will only pay an accelerated benefit for each ABO Eligible Life Insurance benefit once. Definitions for covered losses and illnesses are listed in “Your Benefit Plan” provided by MetLife. If a claim is submitted for insurance benefits other than life insurance benefits, MetLife has the right to ask the insured to be examined by a physician(s) of MetLife’s choice as often as reasonably necessary to process the claim. MetLife will pay the cost of such exam. Please call the Fund Office at (212) 465-8888, option 4 with any questions or for further details.

What are the Requirements for Payment of an Accelerated Benefit?

Subject to the conditions and requirements of the Accelerated Benefit Option MetLife will pay an accelerated benefit to you or your legal representative if:

- the amount of your ABO Eligible Life Insurance benefit to be accelerated cannot exceed $40,000 and
- proof that you are terminally ill is properly filed and received.

Please note MetLife will only pay an accelerated benefit once.

LIFE INSURANCE BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID.

Disclosure: *The Life Insurance Accelerated Benefit Option offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from your income and not subject to federal taxation.* ***You are advised to consult with a qualified tax advisor about circumstances under which you could receive an accelerated benefit excludable from income under federal law.***

Receipt of an accelerated benefit may affect your, your spouse's or your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplemental Social Security Income (SSI), and drug assistance programs. ***You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect your, your spouse's or your family's eligibility for public assistance.***

When Is A Participant Eligible for Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance?

Please refer to the **Active Eligibility** section of this booklet *"When Does My Coverage Become Effective?"* and *"How Do I Maintain Coverage?"* (pages 9 and 10).

What Date Does My Life Insurance Take Effect and Accidental Death and Dismemberment Insurance?

Your life insurance takes effect on the date you become eligible for all health and welfare coverage as an active participant (retired participants do not have life or Accidental Death and Dismemberment coverage).

When Does My Life Insurance and Accidental Death and Dismemberment End?

Your insurance will end on the earliest of the date the group policy ends or the date you lose coverage in the Welfare Fund.

Can I Continue Life Insurance or Accidental Death and Dismemberment Coverage If I Fail to Remain Covered Under the Group Plan?

If your Welfare Fund coverage terminates, you may apply, without medical examination or other evidence of insurability, for an individual life insurance policy through MetLife. You will have the option to convert when:

- Your Life Insurance ends because you cease to be eligible for any reason, including retirement; or
- The Group Policy ends.

Life Insurance or Accidental Death and Dismemberment Coverage Conversion Application Period:

The application period is based on the date your group coverage terminates and the date of the termination notice. Generally, you have 31 days from the date group coverage ends to apply for conversion. However, if you are given written notice of the option to convert dated more than 15 days from the date of termination, your application period is extended for an additional 45 days. If the 45-day extension applies to you, it will not exceed more than 135 days from the date group insurance was terminated.

The option to convert the Life Insurance as well as the maximum amount of the new policy is subject to conditions listed in lengthy detail in “Your Benefit Plan” from MetLife.

If you die during the conversion policy application period *during* the first 31 days of the Application Period, and a new policy did not take effect during this period, MetLife will review the claim and if MetLife approves it, will pay the Beneficiary the amount of Life Insurance under this Group Policy to which the participant was entitled to convert.

If you die after the first 31 days of the conversion policy application period, the claim will be reviewed. If the claim is approved, MetLife will pay the beneficiary from a new individual policy. The amount MetLife will pay is the amount of Life Insurance that you were entitled to convert under the Group Policy.

MetLife will not pay insurance under both a new policy applied for during the conversion policy Application Period and the Group Policy.

What Is Accidental Death and Dismemberment Insurance?

Accidental Death and Dismemberment Insurance will pay you (or, in the event of your accidental death, your designated beneficiary) a benefit if you sustain an accidental injury that is the direct and sole cause of a covered loss described in the schedule of benefits listed hereafter. Proof of the accidental injury and covered loss must be sent to the Welfare Fund. When the proof is received, the claim will be reviewed. If it is approved by MetLife, the insurance claim will be paid if in effect on the date of the injury.

The covered loss must have occurred within 12 months of the date of the accidental injury, must have been a direct result of the accidental injury, independent of other causes, and the covered loss must not have been caused or contributed to by non-accidental events, such as suicide, attempted suicide, intentional self-inflicted injury, physical or mental infirmity or the diagnosis or treatment of such illness or infirmity or by infection (other than infection occurring in an external, accidental wound). Nor may the covered loss be caused or contributed to by voluntary actions such as:

- the voluntary intake or use by any means of any drug, medication or sedative, unless it is:
  - taken or used as prescribed by a physician, or
  - an "over the counter" drug, medication or sedative taken as directed;
- the voluntary intake or use by any means of alcohol in combination with any drug, medication, or sedative; or
- the voluntary intake or use by any means of poison, gas or fumes.

MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Presumption of Death

The participant will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which he or she were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a common carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

Exclusions

Under the Accidental Death and Dismemberment Insurance, MetLife will not pay benefits under this section for any loss caused or contributed to by service in the armed forces or units auxiliary thereto; aviation, other than a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; war, whether declared or undeclared; or act of war, participation in a felony, riot or insurrection.

MetLife will not pay benefits under this section for any loss if you are intoxicated at the time of the incident and are the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

Benefit Payment Schedule

The following schedule shows the benefits that are available under the AD&D Insurance Policy. You will only be insured for the benefits for which you become and remain eligible, which you elect, if subject to election, and which are in effect. The full amount for purposes of the following Schedule of Covered Losses for AD&D Insurance as indicated here is $50,000.

Accidental dismemberment benefits are payable to the participant, but life insurance and accidental death benefits will be paid to the participant's designated beneficiary.

Benefit	***Payable for***
$20,000	loss of life.
$25,000	loss of a hand permanently severed at or above the wrist or below the elbow.
$25,000	loss of foot permanently severed at or above the ankle but below the knee.
$37,500	loss of an arm permanently severed at or above the elbow.
$37,500	loss of a leg permanently severed at or above the knee.
$25,000	loss of sight in one eye.
$12,500	loss of the thumb and index finger of the same hand.
$50,000	loss of any combination of hand, foot, or sight of one eye, as defined above.
$25,000	loss of speech or loss of hearing.
$50,000	loss of speech and loss of hearing.
$12,500	paralysis of one arm or leg.
$25,000	paralysis of the arm and leg on either side of the body.
$25,000	paralysis of both legs.
$50,000	paralysis of both arms and both legs.
$50,000	brain damage. *[See MetLife Insurance's "Your Benefit Plan" for detail.]*
$500/mo.	beginning on 7th day and for the duration of a coma - maximum of 60 months. *[See MetLife Insurance's "Your Benefit Plan" for details.]*

Additional Accidental Death Benefits

The following amounts may be payable in addition to the accidental death benefit in the above Schedule of Benefits under the specified circumstances.

A) **Seat Belt Use:**

An additional $10,000 benefit is payable if the participant's death was caused by an automobile accident in which the participant was wearing a seatbelt that was properly fastened. If the participant was driving at the time of the automobile accident, this Seat Belt Use benefit is payable only if the participant was properly licensed to operate the automobile at the time of the accident. A police officer investigating the accident must certify that the seat belt was properly fastened. A copy of such certification must be submitted to the Welfare Fund with the claim for benefits.

The Seat Belt Use benefit is an additional benefit equal to $10,000. (A detailed definition of a passenger and seat belt may be found in the document Your Benefit Plan.)

B) **Air Bag Use:**

An additional $5,000 benefit is payable if the participant's death was caused by an automobile accident in which the automobile was equipped with airbags. This Air Bag Use benefit is payable only if the participant was wearing a seat belt that was properly fastened at the time of the accident and, if the participant was driving at the automobile accident, only if the participant was properly licensed to operate the automobile at the time of the accident. A police officer investigating the accident must certify that the seat belt was properly fastened and that the passenger car in which the deceased was traveling was equipped with air bags. A copy of such certification must be submitted to the Welfare Fund with the claim for benefits.

The Air Bag Use benefit is an additional benefit equal to $5,000. (A detailed definition of a passenger, seat belt and air bag may be found in the document Your Benefit Plan.)

C) **Child Care:**

If the covered loss of life of the participant occurs as a direct result of an accident, this additional benefit will be paid if, on the date of the participant's death or within 12 months after the date of the participant's death, the participant's child was enrolled in a Child Care Center. Proof of enrollment in a Child Care Center is required.

For each child who qualifies for this benefit, MetLife will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed: an annual maximum of $5,000 and an overall maximum of $6,000. Child Care Center charges will not be paid for after the date a child attains age 12. Benefits will be paid quarterly upon submission of proof of payment to the Child Care Center. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date the participant dies and there is no child who could qualify for it, MetLife will pay $1,000 to the participant's designated beneficiary in one sum.

D) <u>Child Education:</u>

If the covered loss of life of the participant occurs as a direct result of an accident, this additional benefit will be paid if, on the date of the participant's death, the participant's child was (1) enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or (2) at the 12th grade level and, within one year after the date of the participant's death, enrolled as a full-time student in an accredited college, university or vocational school. Proof of enrollment in an accredited college, university or vocational school will be required.

For each child who qualifies for this benefit, MetLife will pay an amount equal to the tuition charges incurred for a period up to 4 consecutive academic years, not to exceed: an academic year maximum of $10,000 and an overall maximum of 20% of the Full Amount shown in the Schedule of Benefits. Benefits will be paid semi-annually upon submission of proof of payment of tuition charges. Payment will be made to the person who pays such tuition charges on behalf of the child.

If this benefit is in effect on the date the participant dies and there is no child who could qualify for it, MetLife will pay $1,000 to the participant's designated beneficiary in one sum.

E) <u>Spouse Education:</u>

If the covered loss of life of the participant occurs as the direct result of an accident, MetLife will pay this additional Spouse Education benefit if, on the date of the participant's death, his or her Spouse (1) was enrolled as a full-time student in an accredited college, university, or vocational school; or (2) within 12 months after the date of the participant's death, the participant's Spouse enrolled as a full-time student in an accredited school.

MetLife will pay an amount equal to the tuition charges incurred for a period up to 1 academic year, not to exceed: an academic year maximum of $1,500 and an overall maximum of 3% of the Full Amount shown in the Schedule of Benefits.

Benefits will be paid semi-annually upon submission of proof of payment of tuition charges. Payment will be made to the Spouse.

If this benefit is in effect on the date the participant dies and there is no Spouse who could qualify for it, MetLife will pay $1,000 to the participant's designated beneficiary in one sum.

F) Hospital Confinement:

If the covered loss of life of the participant occurs as the direct result of an accident, MetLife will pay this additional Hospital Confinement benefit if the participant was confined in a hospital as a result of the accident.

MetLife will pay an amount for each full month of hospital confinement equal to the lesser of 1% of the full amount shown in the Schedule of Benefits or $2,500.

Benefit payments will be made monthly. Payment will be made to the participant's beneficiary.

Please note: This Additional Benefit provides insurance only for ACCIDENTS. It does not provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

G) Common Carrier:

If the covered loss of life of the participant occurs as the direct result of an accident while traveling in a Common Carrier, MetLife will pay this additional benefit amount equal to $50,000. For loss of life the participant's benefits will be paid to his or her beneficiary. A detailed definition of a Common Carrier can be found in the document "Your Benefit Plan."

H) Repatriation of Remains Benefit:

This Plan pays a Repatriation of Remains Benefit for the actual expenses incurred to prepare a person's body for transportation to a mortuary if, as a direct result of an accident for which a benefit is payable under this section, he or she suffers loss of life while outside a 100 mile radius from his or her principal place of residence. The maximum benefit payable is $5,000. Benefits will be paid when proof is provided that the charges described above have been paid. Payment will be made to the person who paid such charges

When and How Do I File A Claim for the Accelerated Benefit Option and the Accidental Death and Dismemberment Benefit(s)?

The request for payment of an Accelerated Benefit Option must be made while ABO Eligible Life Insurance is in effect. For any claim other than ABO and Life both the notice

of claim and the required proof should be sent to the Fund Office within 90 days of the date of a loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonable.

It is essential that you keep your beneficiary information current. Contact the Fund Office if you wish to change or update your beneficiary information.

Failure to do so can delay or prevent payment of your group life and accidental death insurance benefits or result in payment which is not what you wished.

THE HEALTH REIMBURSEMENT ACCOUNT

The Health Reimbursement Account benefit has been designed specifically to provide you and your families with the ability to pay Medical Care Expenses which are not covered by insurance, not covered by the Steamfitters' Industry Welfare Fund or otherwise not covered under another arrangement, as well as to enable you to save for future medical expenses, on a tax-favored basis. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. Only these expenses considered medically or dentally necessary are eligible for reimbursement. The Helper classification does not participate in the Health Reimbursement Account. This account is not subject to reciprocity.

Participant Accounts:

An account is established for each participant under the Plan and is credited with contributions received in accordance with the collective bargaining agreement. If the Plan's investment income exceeds its expenses, each account will be credited with an allocable share of the Plan's investment income. Benefit disbursements will be deducted from your account. In addition, amounts previously contributed to the Security Benefit Fund may be transferred as contributions to your HRA account.

Contributions to your account become available to you after they have been posted to your account. Benefits paid to you from your account are deducted from your balance on the date paid. The amount of benefits available to you is limited to the balance in your account.

The maximum balance in your account cannot exceed $5,000. Any balance in excess of this amount will be transferred on a quarterly basis to your Supplemental Retirement Fund (401(a) Plan) account.

Who is Eligible for Health Reimbursement Benefits?

You, the participant of the Steamfitters' Industry Welfare Fund, as well as your qualified dependent(s) enrolled in the Welfare Fund, are eligible for benefits from the Health Reimbursement Account at any time, provided you have a properly documented claim for benefits, that you submit the claim timely, and that you have a balance in your account upon the Fund Office's receipt of your application. Other dependents are not eligible.

If you are no longer eligible to receive additional contributions to your HRA, you are still eligible to receive reimbursement from the HRA until your account balance is exhausted.

After a participant's death, substantiated Medical Care Expenses for the deceased participant may be submitted for reimbursement. Eligible dependents may continue to submit their own claims for Medical Care Expenses until the deceased participant's account is exhausted. There is no time limit in which the account must be exhausted. If,

or when, there are no eligible dependents in the Welfare Fund the balance in the account will be forfeited to the Plan.

How Long is a Claim Eligible for Reimbursement?

Generally, your Health Reimbursement Account will accept properly documented claims for benefits for dates of service up to one year from the date the reimbursable expense was incurred. (Please note: A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care or service.)

What is the Minimum Dollar Amount for which a Claim Will Be Processed?

In order to limit the costs of the administration of the Plan, it is requested that you accumulate a minimum of $100 in receipts in order for the Fund Office to process your reimbursement request.

The $100 minimum is not applicable **ONLY IF:**

- You are enrolled in EFT (Electronic Funds Transfer); **or**
- Your unreimbursed medical expense is at least 11 months old (from date the date incurred) but no greater than 1 year old.

What Happens if I Don't Have a Sufficient Balance to Cover my Claim?

If, at any time your application is received and your claim is for an amount greater than the balance in your HRA account, you may transfer the difference between the application amount and your HRA account balance from your Security Benefit Fund. The transfer amount cannot exceed your Security Benefit Fund account balance and is not subject to tax.

What Must I Submit with my Claim for Benefits?

You may apply for reimbursement by submitting the required application to the Fund Office. To contact the Fund Office for a form, please call (212) 465-8888, option 8 or you may find the form on the website at **www.steamfitters.com**. The form will require you to provide:

- The name of the person (you or your qualified dependent(s)) on whose behalf the expenses which qualify for reimbursement were incurred; and

- The nature of the expenses that were incurred; and
- The amount of the requested reimbursement; and
- A statement that the expenses have not been reimbursed and are not reimbursable through any other source.

The application for reimbursement must be accompanied by bills, invoices, medical Explanation of Benefits, dental expense statements, Medicare Part B premium proofs, or other satisfactory third-party statements showing that the reimbursable expenses have been incurred and the amounts of such expenses. You must also furnish any additional information which the Plan may require.

How Long Will It Generally Take for the Processing of a Claim?

In general, within 30 days of receipt of a claim by the Fund Office, the Fund Office will reimburse the claim if the claim is approved or notify you that the claim is denied. This 30-day period may be extended for an additional 15 days for matters beyond the Fund Office's control, including a case in which the reimbursement claim is incomplete. The Fund Office will provide written notice of any extension, including the reason for the extension. If the problem is an incomplete reimbursement claim, you will be allowed 45 days in which to complete the claim.

Which Expenses are Reimbursable?

The following expenses, not already covered by insurance, are reimbursable:

- Medical
- Hospital
- Dental
- Vision care
- Hearing aid
- Medicare Part B & D premiums
- COBRA premiums
- Qualified Long-Term Care services
- Assisted living medical costs
- Other healthcare insurance *(Co-payment, coinsurance, deductibles)*

- Only those over-the counter (OTC) medicinal products which are FSA eligible.

The definitions for these expenses are as follows:

Medical Care Expenses: These expenses are covered when they are incurred. A medical care expense is incurred at the time the medical care or service giving rise to the expense is furnished and ***not*** when you are billed for it. A "Medical Care Expense" as defined in Internal Revenue Code Section 213 is the "amount paid for the diagnosis, cure, mitigation, treatment, or prevention of disease for the purpose of affecting any structure or function of the body." Medical care expenses **do not** include costs incurred for cosmetic surgery and similar procedures not necessary to ameliorate (improve) a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" for this purpose means a procedure directed to "improving the patient's appearance" that does not "meaningfully promote the proper function of the body or prevent or treat illness or disease."

"Medical care" includes treatments by persons who are not licensed to practice medicine or nursing in the conventional sense, such as chiropractors and psychologists. In order to qualify as medical care, the practitioner's services must be addressed to a physical or mental disability, not to the participant's general wellbeing. For the purpose of the Plan, "Medical care" includes transportation only by ambulances and similar vehicles.

Hospital Medical Care Expenses: While in the hospital, the amount actually paid for medically necessary hospital services. Please contact the Fund Office for further details.

Dental Expenses: The amount actually paid for dental services, excluding cosmetic dentistry.

Vision Care: Eye examinations, frames, and/or lenses including contact lenses. (Non-prescription sunglasses are not eligible for reimbursement).

Hearing Aid: A small electronic apparatus that amplifies sound and is worn in or behind the ear to compensate for impaired hearing.

Medicare Part B & D Premiums: Part B - The amount paid for Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Medicare Part A.

Part D – the Medicare Part D Prescription Drug Plan is a Medicare sponsored insurance plan, sold and administered through private insurance companies, to cover prescription drug costs for people on Medicare.

COBRA Premiums: The amount paid for a health insurance plan which allows an individual that loses health insurance coverage to continue to be covered under the health plan, for a certain time period and under certain conditions.

Qualified Long-Term Care Expenses: Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services required by a "chronically ill individual" that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Medical care does not include long-term care expenses paid to relatives or businesses owned in whole or in part by you or your relatives unless the expenses are for services performed by a relative who is a licensed health care professional.

Assisted Living Medical Costs: The medical care portion of a retirement home or assisted living facility monthly life-care fee is also considered a medical expense. The percentage method is used to determine the medical care portion. For further details and an explanation as to how to determine this expense, please contact the Fund Office.

Other Healthcare Insurance:

- **Co-payment:** The portion of a claim or medical expense that a participant must pay out of his or her own pocket to a provider or a facility for each service.

- **Coinsurance**: A provision in a participant's coverage that limits the amount of coverage by the plan to a certain percentage. Additional costs are paid by the participant, which is referred to as coinsurance.

- **Deductibles:** The dollar amount a participant must pay each year before his or her medical and/or dental plan begins to pay benefits for certain covered expenses.

- **Over-the-Counter Products Prescribed by an Appropriate Health Care Provider:** Only those over the counter (OTC) medicines and drugs which are accompanied by a prescription.

Which Expenses are Not Reimbursable?

Medical care expenses which are eligible for payment or reimbursement by any other accident or health plan are not reimbursable from the HRA. If the other plan does not fully cover your medical expenses, for example, because of co-payment or deductible limitations, this Plan can reimburse the remaining portion of the expense so long as the claim satisfies the definition of expenses covered by the Plan.

Coverage under a Group Health Plan

Beginning January 1, 2014, and applicable only to contributions made to the HRA Plan on your behalf, and eligible claims incurred by you or your dependents as of January 1, 2014 or later, in order to be eligible for benefits from the HRA Plan, you must be enrolled in a group health plan, either through the Fund, another employer or one sponsored by your spouse's employer. You are not eligible for reimbursement from the HRA Plan unless you are enrolled in a group health plan that provides at least Minimum Value as described below (including the Steamfitters' Industry Welfare Fund). You will be required to provide the Fund with proof of enrollment in a group health plan if you are not enrolled in the Welfare Fund.

Proof of Coverage

Proof of other group health plan coverage that provides Minimum Value is required, in a manner to be determined by the Trustees. If proof is not provided, benefits will be restricted, as described below.

Minimum Value

A group health plan provides Minimum Value if the coverage has an actuarial value of at least 60 percent under the actuarial value of a standard plan as determined by the IRS. Proof of Minimum Value may be found on the group health plan's Summary of Benefits and Coverage (SBC). You will be required to provide a copy of the SBC at the time you submit a claim for benefits.

Benefits are Not Payable for Individual Insurance

In no event are premiums for individual health insurance a reimbursable Medical Care Expense, whether purchased in the individual insurance market or in a Health Insurance Marketplace.

Opt-Out

Upon termination of coverage under your group health plan, i.e., either the Fund or one sponsored by another employer or your spouse's employer, you must opt-out of and waive future reimbursements from the HRA at least once per year, in a time and manner determined by the Trustees. This opt-out is applicable only to those contributions made to the HRA Plan on your behalf prior to the date you elect to opt-out of the Plan. This does not preclude any future contributions being made to the HRA Plan on your behalf based on future employment.

HRA Rules and Regulations

Investment Earnings

After the close of each Plan Year, if the net investment income of the Fund exceeds expenses, at the direction of the Trustees, the net amount may be proportionally allocated to each participant's account balance.

Assignment of Benefits

You may not assign or use as collateral any part of your account balance or any benefits you are entitled to from the Fund.

Coordination of Benefits

In no event shall the combined reimbursement payable to a Participant with respect to any Medical Care Expense, from this Plan and all other sources, exceed one hundred percent of such Medical Care Expense.

Fraudulent Claims

If you file a claim for benefits which the Trustees determine is based upon misrepresentation or fraudulent conduct on your part, the Trustees shall deny the claim and will suspend all payments to or withdrawals by you from the Fund for a period of one year for the first offense and two years for any subsequent offense.

Indemnification of Plan Sponsor

If any Participant receives one or more payments or reimbursement under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Plan Sponsor for any liability it may incur for failure to withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

STEAMFITTING INDUSTRY ASSISTANCE PROGRAM

The Steamfitting Industry Assistance Program (SIAP or the Assistance Program) was one of the first Assistance Programs in the Building and Construction Trades Industry and has been helping participants and their families since 1986. Through the Program, resources are available to assist both active and retired members as well as their families with alcohol, drug, prescription drug, pain medications and other mental health issues.

Addiction is not intentional, but, left untreated, it can destroy families and take lives. The Program refers participants and their families to Inpatient and Outpatient Treatment. Once inpatient treatment has been completed, participants may attend SIAP's internally developed aftercare program.

To contact the Steamfitting Industry Assistance Program, the direct phone number is (212) 563-0378. You can be assured that anyone who calls the Assistance Program will receive completely confidential assistance.

CLAIM FILING PROCEDURES

HOSPITAL

Empire EPO

Should you or any of your dependents require emergency care or admission to a participating hospital, you should present your Empire BlueCross BlueShield identification card at the time of service. The hospital will bill Empire for benefits payment. No claim forms are required for hospital coverage. See the EPO Guide, the blue pages at the end of this booklet, for more information about your hospital coverage.

MEDICAL BENEFITS

Empire EPO

There are no claim forms to file for medical benefits for services rendered by participating EPO providers. You simply identify yourself as a member of the EPO by showing your identification card to the provider and make any required co-payment. The providers are responsible for filing all claims for benefits directly with Empire BlueCross BlueShield. See the EPO Guide, the blue pages at the end of this booklet, for more information about your hospital coverage.

DENTAL BENEFITS

MetLife Preferred Dentist Program

No claim forms are required if you see a Preferred Dentist. The Preferred Dentist will submit your claim for you, and MetLife will pay the dentist directly.

You are responsible for paying for services from Non-Network Dentists and requesting reimbursement from MetLife. All necessary forms for dental work can be obtained by calling MetLife at (800) 942-0854. Claim forms can be downloaded from the MetLife website, metlife.com/dental**.** Access specific information about dental claims at metlife.com/mybenefits.

If you require treatment in excess of $300, you and your dentist should submit a pre-treatment estimate outlining the treatment plan and related charges. This way, you will know what services MetLife will cover and at what payment level. Services that usually require a pre-treatment estimate include crowns, bridges, inlays, onlays and periodontics.

Initial Determination for Claims Other Than Urgent Care Claims

After you submit a claim for Dental Insurance benefits to MetLife, MetLife will review your claim and notify you in writing of its decision to approve or deny your claim.

Such notification will be provided to you within a 30-day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30-day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

The denial will also include a statement of your right to make an appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

It will also describe your right to bring civil action to enforce your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

PRESCRIPTION DRUG PROGRAM

Express Scripts, Inc.

No claim forms are required for prescriptions obtained through the Mail Service or Retail Program. If you are required to purchase a prescription at a non-participating pharmacy because of circumstances beyond your control, contact the Fund Office at (212) 465-8888, option 4 to obtain a Direct Reimbursement Claim form. You may be reimbursed significantly less than your purchase price of the prescription. After you and your pharmacist have completed the claim form, return it to the Fund Office for processing.

VISION CARE & HEARING AID BENEFITS

There is a special claim form for these benefits. Should you or any of your qualifying dependents require an application, please contact the Fund Office at (212) 465-8888, option 8 or please visit the website, **www.steamfitters.com**. After you have completed the application and followed its specific instructions, submit it to the Fund Office for processing. An itemized receipt for the services rendered or products purchased must accompany the application.

In general, claims for Vision Care Benefits and Hearing Aid Benefits are paid or denied within 30 days of receipt of a claim by the Fund Office. This 30-day period may be extended for an additional 15 days for matters beyond the Fund Office's control, including a case in which the claim is incomplete. The Fund Office will provide written notice of any extension, including the reason for the extension. If the problem is an incomplete claim, you will be allowed 45 days in which to complete the claim.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The claimant(s) must contact the Fund Office at (212) 465-8888, option 4 to commence the process to file a claim for Life Insurance or Accidental Death and Dismemberment Insurance. Except in case of application for the Advanced Benefit Option, claims must be submitted within 90 days of the date of loss (or otherwise as soon as possible).

After the Fund Office forwards your claim to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

APPEAL OF DENIED CLAIMS

The following explains how to appeal denied claims in the Welfare Fund:

Hospital and Medical Benefits

The appeals and grievances procedures for hospital and medical claims for services provided by Empire BlueCross BlueShield – EPO are set forth in the Empire EPO Guide at the end of this booklet. If you exhaust Empire's internal appeals procedures and receive an adverse determination with Empire, you may appeal to the Welfare Fund's Board of Trustees.

Prescription Drugs

You should first appeal your denial of Prescription Drug claims with Express Scripts. If you exhaust Express Script's internal appeals procedures and receive an adverse determination, you may appeal to the Welfare Fund's Board of Trustees.

There are two types of appeals: clinical coverage and administrative coverage reviews.

How to request an initial coverage review of your prescription drug claim:

The preferred method to request an initial clinical coverage review, based on clinical conditions of coverage i.e. medications that require a preauthorization, is for the prescriber or dispensing Pharmacist to call the Express Scripts Coverage Review Department at (800) 753-2851. Alternatively, the prescriber may submit a completed coverage review form to fax number (877) 329-3760. Forms may be obtained online at express-scripts.com/services/physicians/. Requests may also be mailed to: Express Scripts, Attn: Prior Authorization Dept., PO Box 66571, St. Louis, MO 63166-6571. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the prescription.

To request an initial administrative coverage review, based on the Plan's benefit design, the member or his or her representative must submit the request in writing to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587
St Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at (800) 753-2851.

How a prescription drug initial coverage review is processed:

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support his or her request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service* Standard Post-Service*	15 days (Retail) 5 days (home delivery) 30 days	Patient: automated call *(letter if call not successful)* Prescriber: Fax *(letter if fax not successful)*	Patient: letter Prescriber: Fax *(letter if fax not successful)*
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax *(letter if fax not successful)*	Patient: live call and letter Prescriber: Fax *(letter if fax not successful)*

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

How to request a level 1 prescription drug appeal or urgent prescription drug appeal after an initial coverage review has been denied:

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Express Scripts, Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax: (877) 852-4070

Administrative review requests: Express Scripts, Attn: Benefit Coverage Review Department, PO Box 66587, St Louis, MO 63166-6587. Fax: (877) 328-9660

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone (800) 935-6103 or fax (877) 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 prescription drug appeal or urgent prescription drug appeal is processed:

Express Scripts completes appeals per business policies that are compliant with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Specialist, panel of clinicians or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service* Standard Post-Service*	15 days (Retail) 5 days (home delivery) 30 days	Patient: automated call *(letter if call not successful)* Prescriber: Fax *(letter if fax not successful)*	Patient: letter Prescriber: Fax *(letter if fax not successful)*
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax *(letter if fax not successful)*	Patient: live call and letter Prescriber: Fax *(letter if fax not successful)*

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a level 2 prescription drug appeal after a level 1 appeal has been denied:

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination

- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Express Scripts, Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax: (877) 852-4070

Administrative review requests: Express Scripts, Attn: Benefit Coverage Review Department, PO Box 66587, St Louis, MO 63166-6587 Fax: (877) 328-9660

An urgent level 2 appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by Phone: (800) 935-6103 or Fax: (877) 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 prescription drug appeal is processed:

Express Scripts completes appeals per business policies that are compliant with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Specialist, and panel of clinicians or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service* Standard Post-Service*	15 days (Retail) 5 days (home delivery) 30 days	Patient: automated call *(letter if call not successful)* Prescriber: Fax *(letter if fax not successful)*	Patient: letter Prescriber: Fax *(letter if fax not successful)*
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax *(letter if fax not successful)*	Patient: live call and letter Prescriber: Fax *(letter if fax not successful)*

When and how to request an external review of your prescription drug claim:

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to: MCMC, LLC, Attn: Express Scripts Appeal Program, 300 Crown Colony Drive, Suite 203, Quincy, MA 02169. Phone: (617) 375-7700 ext. 28253 Fax: (617) 375-7683 and the request must be received within four (4) months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

How an external review of a prescription drug claim is processed:

Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claim's administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Dental Benefits

You should first appeal your denial of Dental Benefit claims with MetLife. If you exhaust MetLife's internal appeals procedures and receive an adverse determination, you may appeal to the Welfare Fund's Board of Trustees.

Appealing the Initial Determination of Dental Claims - First Level of Review

If MetLife denies your claim, you may take two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination

- An explanation why you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim such as diagnostic materials, x-rays, or narrative.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will consider all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a dental judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

A denial of your first request for appeal will also include a statement of your right to make a second appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

Each denial of an appeal will also describe your right to bring civil action to enforce your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

Finally, each denial of an appeal will describe your right to request an additional, external review under New York state law.

Second Level of Review of a Dental Claim

If the appeal is not resolved to your satisfaction, you can appeal the action to second level of review for reconsideration. Decisions on your appeal in the second level of review will be made no later than 30 days after receipt of the request for reconsideration.

After MetLife receives your written request for a second level of review, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial or the initial appeal, and MetLife's review will look at the claim anew. The review on the second appeal will consider all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination or on the initial appeal. The person who will review your second appeal will not be the same person as the person who made the initial decision or the person who made the decision on the initial appeal to deny your claim. In addition, the person who is reviewing the second appeal will not be a subordinate of the person who made the initial decision or the person who made the decision on the initial appeal to deny your claim. If the initial denial or the denial on the initial appeal is based in whole or in part on a dental judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination or on the initial appeal and will not be a subordinate of any person who was consulted on the initial determination or the initial appeal.

If your second level of review also denies your claim, your written notice of denial will contain the same items of information that were contained in your initial appeal notice.

Please note, by undertaking a second level review you may foreclose your right to an external appeal as an external appeal must be filed within 45 days of the Final Adverse Determination of the first level review.

External Procedures for Dental Claim Review Outside of MetLife

New York state law gives you the right to an external appeal when payment of benefits for dental services have been denied on the basis that the services are not Dentally Necessary or that the services are experimental or investigational. This applies both to Urgent Care Claims and non-Urgent Care Claims.

If you have received a Final Adverse Determination after our first level of review, you can request an external appeal by completing an application form and sending it to the New York State Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Final Adverse Determination means a written notification from us that your claim for dental benefits has been denied through our appeal process.

You may obtain an application form or any additional information by calling us at (800) 275-4638 or by calling the New York Insurance Department at (800) 400-8882. You may also obtain an application or further information by visiting the New York Insurance Department's web site at www.ins.state.ny.us.

Eligibility for an External Appeal of a Dental Claim

To be eligible for an external appeal, payment of benefits for dental services must have been denied on the basis that the services are not Dentally Necessary or that the services are experimental or investigational and:

- You must have received a Final Adverse Determination as a result of our internal utilization review appeal process; or
- You and MetLife must have agreed to waive that appeal process.

If services are denied as experimental or investigational, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal and your Dentist must complete the Attending Physician Attestation form and send the form to the New York Insurance Department. The Attending Physician Attestation form is included as part of the application form.

You may only appeal a service or procedure that is a Covered Service under this certificate. The external appeal process may not be used to expand your dental coverage.

Submission of Information for External Review of a Dental Claim

If your case is determined to be eligible for external review, you will be notified by the New York Insurance Department of the certified external appeal agent assigned to review your case.

MetLife will send your dental and treatment records to the external appeal agent.

When the external appeal agent reviews your case, the agent may request additional information from you or your Dentist. This information should be sent immediately to the external appeal agent. You and your Dentist can submit information even when the external appeal agent has not requested specific information. You must submit this information to the Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Once the external appeal agent makes a determination or your 45-day time period ends, you will not be able to submit additional information.

The external appeal application contains a release of medical records provision that you must sign to authorize the release of medical and treatment records, including HIV, mental health and alcohol and drug abuse records to the certified external appeal agent assigned to review your appeal.

Eligibility for an Expedited External Appeal of a Dental Claim

If your attending Dentist attests that a delay in providing the treatment or service poses an imminent or serious threat to your health, you may request an expedited appeal. When requesting an expedited appeal, make sure you give the Attending Physician Attestation form to your Dentist to complete. Your appeal will not be forwarded to the external appeal agent until your Dentist sends this attestation to the Insurance Department.

Time Periods for External Appeals of Dental Claims

For standard appeals, the external appeal agent must make a determination within 30 days of receiving your request for an external review from the state. If additional information is requested, the external appeal agent has five additional business days to make a determination. For expedited appeals, the external appeal agent must make a determination within three days of receiving your request for an external review from the state.

The Cost to You for an External Appeal of a Dental Claims

We may charge you a fee of up to $50.00 for an external appeal. If we determine that the fee will pose a hardship, you will not be required to pay a fee.

If the external appeal agent overturns the Final Adverse Determination, the fee will be refunded to you.

Notification of a Decision on External Review of a Dental Claim

When the external appeal agent has made the decision:

- for standard appeals, you and MetLife will be notified in writing within two business days; or
- for expedited appeals, you and MetLife will be notified immediately by telephone or fax. Written notification will follow.

The decision of the external appeal agent is binding on you and MetLife.

Final Appeal of Medical, Prescription Drug, and Dental Benefits to Board of Trustees

After you have exhausted your internal appeals with the following:

- Empire BlueCross BlueShield for Hospital and Medical Benefits
- Express Scripts for Prescription Drug Benefits
- MetLife for Dental Benefits

You may appeal the company's decision to the Board of Trustees. Appeals should be made in writing and sent, within 180 days of the receipt of the denial of the final internal appeal, and sent to:

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You or your authorized representative may examine Plan records relating to your claim, without charge.

Your appeal must be made in writing and sent to the Fund Office within 180 days of the notification that your claim has been denied on review. You may submit written comments, documents, and other information relating to your claim, regardless as to whether such information was submitted or considered in the initial claim determination. You will be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to your claim. You have the right to have another person represent you in your appeal.

The Trustees will respond to your appeal within 60 days, unless special circumstances make it necessary for them to take an additional 60 days to review your request. You will be notified of the need for an additional 60 days, and a description of the reason additional time is needed, before the end of the initial 60-day period.

The Board's review will take into account all comments, documents, and other information that you have submitted, whether or not such information was submitted or considered in the initial benefit determination. The Board's review will not provide deference to the denial by Empire, Express Scripts, or MetLife (as applicable). If the denial is based in part on a medical judgment, the Board will consult with a health care professional with appropriate training and experience who is independent of any health care professional consulted in the original consideration of your claim or consideration of your claim on appeal. Any medical or vocational experts consulted will be identified even if the Board does not rely on their advice in making the determination on appeal.

Notice of Board of Trustee's Decision:

You will be provided with written notice of the Board's decision on your appeal (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol, was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation for the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If you feel that legal action concerning your claim is necessary, legal process may be served upon the Administrator, or upon one or more of the Trustees at the address shown in the front of this booklet. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. Any lawsuit filed against the Plan must be filed no more than one year after a final decision on review is reached.

Vision Care Benefit, Hearing Aid Benefit and the Health Reimbursement Account

If your claim for Vision Care Benefits, Hearing Aid Benefits, or HRA reimbursement is denied, you will be provided with a written notice of denial of your claim (whether denied in whole or in part).

This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A description of any additional information necessary to perfect the claim, and an explanation of why the material or information is necessary,

- A description of the appeal procedures and applicable time limits,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of medical necessity or because the treatment was experimental, or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim or a statement that is available upon request at no charge.

If you disagree with the denial of your claim, you may contact the Executive Administrator and request review within 180 days of your receipt of the denial of your claim. You may submit written comments, documents, and other information relating to your claim. You will be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to your claim. You have the right to have another person represent you in your request for review or appeal.

The Executive Administrator's review will take into account all comments, documents, and other information that you have submitted, whether or not such information was submitted or considered in the initial benefit determination. The Executive Administrator's review will not provide deference to the initial denial. If the denial is based in part on a medical judgment, the Executive Administrator will consult with a health care professional with appropriate training and experience who is independent of any health care professional consulted in the original consideration of your claim. Any medical or vocational experts consulted will be identified even if the Executive Administrator does not rely on their advice in making the determination on appeal. The Executive Administrator will notify you of the determination on review within 30 days after receipt of your request for review of the denial of your claim.

If the Executive Administrator denies your claim on appeal, you may appeal to the Board of Trustees. Your request for a review of the Executive Administrator's adverse determination on your appeal of your denied claim should be made in writing and sent to:

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

Your appeal must be made in writing and sent to the Fund Office within 180 days of the notification from the Executive Administrator that your appeal has been denied. You may submit written comments, documents, and other information relating to your claim. You will be provided, upon request and free of charge, access to and copies of all documents,

records and other information relevant to your claim. You have the right to have another person represent you in your request for review or appeal.

The Board's review will take into account all comments, documents, and other information that you have submitted, whether or not such information was submitted or considered in the initial benefit determination. The Board's review will not provide deference to the denial by the Executive Administrator. If the denial is based in part on a medical judgment, the Board will consult with a health care professional with appropriate training and experience who is independent of any health care professional consulted in the original consideration of your claim or in the Executive Administrator's consideration of your claim. Any medical or vocational experts consulted will be identified even if the Board does not rely on their advice in making the determination on appeal.

Your appeal will be presented at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review provided the appeal has been received at least 30 days before such meeting. However, if your request for review is not received within 30 days of the next regularly scheduled meeting, your request for review 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. Once a decision on review of your claim has been reached, you will be notified of the decision no later than five (5) days after the decision has been reached.

If special circumstances require an extension of time for processing the claim, written notice of such extension, and a description of the special circumstances, must be given to you prior to the end of the review period. If such an extension is required, you will receive notice of a decision on the claim no later than five (5) days following the third regularly scheduled Board meeting following the initial submission of the claim. If notification of decision is not given within a period described herein, the claim will be considered denied.

You must seek review of a denied claim before seeking relief in court. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has lapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them following your request for review. Any lawsuit filed against the Plan must be filed no more than one year after a final decision on review is reached.

Notice of Decision:

You will be provided with written notice of a denial of your claim on review (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol, was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation for the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Life Insurance and Accidental Death and Dismemberment Benefits

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered

by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

MISCELLANEOUS PROVISIONS

Assignability

Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, and any attempt to alienate any amount, whether presently or hereafter payable shall be void, provided that benefits payable at any time may be used to make direct payments to health care providers upon written authorization of the participant. The Fund shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable through the Welfare Fund, or any part thereof.

Filing of Information

Each eligible participant, qualifying dependent or other interested person shall file with the Welfare Fund such pertinent information as requested, including proof or continued proof of eligibility or dependency, and in such a manner and form as the Fund may specify or provide. Failure to file the requested information will result in the suspension of entitlement to any benefits hereunder until such time as said information is filed by the covered person or on behalf of the covered person.

Misstatements

In the event of any misstatement of fact(s) affecting coverage and/or benefits under the Welfare Fund, the true facts will be used to determine the proper coverage and the participant or qualifying dependent will be liable to repay the Fund for any excess coverage or benefits provided on the basis of the misstatement. The Trustees have sole and absolute discretion to determine eligibility for benefits and the type and amount of benefits to which a participant or beneficiary is entitled.

Overpayments

If a covered person has been paid benefits by the Welfare Fund that either should not have been paid or are in excess of the benefits that should have been paid, the Fund may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such covered person or other present or future amounts payable to such person. The Fund, in its sole discretion, may also recover such amount by any other legal means. Each covered person hereby authorizes the deduction of such excess payment for such benefits or other present or future compensation payments.

No-Fault Benefits

If a person covered by this Plan has a claim, which involves a motor vehicle accident covered by the “no-fault” insurance law of any state, health care expenses must be

reimbursed first by the no-fault insurance carrier. Only when the claimant has exhausted his or her health care benefits under the no-fault coverage will he or she be entitled to receive health care benefits under this Plan. If there are expenses for services that are covered under this Plan and which are not completely reimbursed by the no-fault carrier, such expenses may be reimbursed under this Plan, subject to the Plan's applicable maximums and other provisions.

Payment To Other Than Participant

If it is determined that any person to whom benefits are payable is unable to care for personal affairs; is a minor; or has died, then any payment due the participant or his/her estate may be paid to the duly appointed legal representative, spouse, child, other relative or an institution maintaining or having custody of such person otherwise entitled to payment. The Trustees have sole and absolute discretion to determine to whom the payment will be made. Any such payment shall be a complete discharge of the liabilities of the Fund Office. The Fund may, at its discretion, hold any such payments until a legal representative is appointed.

Right Of Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Welfare Fund may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any potential or current covered person who benefits from the Fund's coverage.

In so acting, the Welfare Fund shall be free from any liability that may arise with regard to such action. Any covered person claiming benefits shall furnish to the Welfare Fund information which may be necessary to implement this provision.

Notice Of Exclusion

As to those participants who elect to exclude themselves from a Worker Compensation and Employer Liability insurance policy, pursuant to a New York exclusion of Executive Officer, by executing a Worker's Compensation policy endorsement, take note: said individuals will not be covered under this Plan in the event that the injuries suffered by said excluded individual are work-related and/or occurred on the job. Said work-related and/or occupational injuries which, except for the election to exclude, would be covered under the employer's Worker Compensation and Employer Liability insurance policy have been specifically excepted by the policies of insurance the Fund has with its benefit providers or insured certificates or insurance contracts.

Newborns' and Mothers' Protections

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act 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 deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

SUBROGATION

The Welfare Fund has the right of subrogation. These provisions apply when the Welfare Fund pays benefits as a result of injuries or illnesses you sustained, and you have a right to a Recovery or have received a Recovery from any source. “You” refers to the participant and/or the participant’s beneficiary. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. The Plan shall be fully subrogated to any and all rights of recovery and causes of action which you may have against any liable third party or insurer. The right reimbursement comes first, even if you are not paid for all of your claims for damages or if the payment you receive is for damages other than medical expenses. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

SUBROGATION

The Welfare Fund has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Welfare Fund has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries. The Fund’s right of subrogation and reimbursement will not be effected, reduced or eliminated by the make whole doctrine, comparative fault, the common fund doctrine, or any other doctrine purporting to defeat the Fund’s right by allocating the proceeds exclusively, or in part, to non-medical expense damages.
- You and your legal representative must do whatever is necessary to enable the Welfare Fund to exercise the Welfare Fund's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the Welfare Fund to exercise its subrogation rights, the Welfare Fund shall be entitled to deduct the amount the Welfare Fund paid from any future benefits under the Welfare Fund.
- The Welfare Fund has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid by the Welfare Fund.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Welfare Fund's subrogation claim and any claim held by you, the Welfare Fund's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The Welfare Fund is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Welfare Fund's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Welfare Fund.
- The Welfare Fund, once benefits are paid, is granted a lien on the proceeds of any payment, settlement, judgment or order received by or due to you. You consent to this lien and agree to cooperate with the Welfare Fund to affect the Fund's subrogation rights.
- You cannot assign any rights or causes of action that you might have against a third-party tortfeasor to recover medical expenses without the express.

REIMBURSEMENT

This Plan is granted a specific and first right of reimbursement out of any Recovery, whether by settlement, judgment, order or otherwise that you or your beneficiary receive from a third-party or insurer. If you obtain a Recovery and the Welfare Fund has not been reimbursed for the benefits the Welfare Fund paid on your behalf, the Welfare Fund shall have a right to be reimbursed from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Welfare Fund from any Recovery to the extent of benefits the Welfare Fund paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Welfare Fund shall have a right of full recovery, in first priority, against any Recovery. Further, the Welfare Fund's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Welfare Fund the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney's fees, other expenses or costs) to be paid to the Welfare Fund immediately upon your receipt of the Recovery. You must reimburse the Welfare Fund, in first priority and without any set-off or reduction for attorney's fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Welfare Fund.
- If you fail to repay the Welfare Fund, the Welfare Fund shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Welfare Fund has paid or the amount of your Recovery whichever is less, from any future benefit under the Welfare Fund if:
  - The amount the Welfare Fund paid on your behalf is not repaid or otherwise recovered by the Welfare Fund; or

- You fail to cooperate with the Welfare Fund in its exercise of its subrogation or reimbursement rights.

- In the event that you fail to disclose the amount of your settlement to the Welfare Fund, the Welfare Fund shall be entitled to deduct the amount of the Welfare Fund's lien from any future benefit under the Welfare Fund.
- The Welfare Fund shall also be entitled to recover any of the unsatisfied portion of the amount the Welfare Fund has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Welfare Fund has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Welfare Fund will not have any obligation to pay the Provider or reimburse you.
- The Welfare Fund is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

YOUR DUTIES

- You must notify the Welfare Fund promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Welfare Fund in the investigation, settlement and protection of the Welfare Fund's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Welfare Fund to exercise its subrogation or reimbursement rights, the Welfare Fund shall be entitled to deduct the amount the Welfare Fund paid from any future benefits under the Welfare Fund.
- You must not do anything to prejudice the Welfare Fund's rights.
- You must send the Welfare Fund copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Welfare Fund if you retain an attorney or if a lawsuit is filed on your behalf.

As with all other terms and conditions of this Plan, the Welfare Fund Trustees have sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Welfare Fund in its entirety and reserve the right to make changes as they deem necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to all of the aforesaid provisions. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery, because of injuries sustained by the covered person, that Recovery shall be subject to all of the aforesaid provisions.

The Welfare Fund is entitled to recover its attorney's fees and costs incurred in enforcing any of the aforesaid provisions.

The subrogation process is being handled by Meridian Resource Company, LLC, in conjunction with their relationship with Empire BlueCross BlueShield. Should a potential subrogation case be identified, Meridian will send a letter and questionnaire to you to start the recovery process. If there is a lawsuit involved, the subrogation process will monitor the lawsuit to be sure that the Welfare Fund is fully repaid for any health care costs (including, but not limited to hospital, medical, prescription, drug, dental costs, etc.) it may have expended.

YOUR RIGHTS UNDER ERISA

As a participant in The Steamfitters' Industry Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Fund Office and at the Union Office, all documents governing the Plan, including insurance or group health contracts, collective bargaining agreements and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report and Plan Document/Summary Plan Description, upon written request to the Fund Office. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- Continue health care coverage for yourself, Spouse or Dependent Children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document/Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ceases.
- You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for 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 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 Fund benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a Welfare Fund 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 the Plan documents or the latest annual report materials from the Welfare Fund 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 Fund 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 Executive 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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in federal court. If it should happen that the Plan "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 a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquires, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration (EBSA). For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you. You may also find answers to your questions at the EBSA website at: dol.gov/ebsa

QUALIFIED MEDICAL SUPPORT ORDER (QMCSO)

According to federal law, a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the Plan and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires someone who is not covered by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to heath care coverage for any of the employee's Dependent Children, the Fund Administrator or its designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the participant is covered by the Plan, the Fund Administrator or its designee will notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren).

A QMCSO may not require that a plan provide any Plan benefits that are not otherwise provided under the Plan. However, if the employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.

If the employee is not covered by the Plan at the time the QMCSO is received and the QMCSO orders the employee to provide coverage for the Dependent Child(ren) of the employee, the Plan will accept a Special Enrollment of the employee and the Dependent Child(ren) specified by the QMCSO. Coverage of the employee and the Dependent will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan, including the exclusion of pre-existing conditions, insofar as is permitted by applicable law.

Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates, for any reason including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA continuation coverage if it applies.

If you have questions about, or wish to obtain a copy of, the procedures governing how the Fund determines if a medical child support order is a QMCSO (at no charge), contact the Fund Office at (212) 465-8888, option 4.

HIPAA PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

Introduction

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, requires that health plans like the Fund protect the confidentiality of your private health information.

Section 1: Purpose

The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Fund's duties with respect to your PHI,
4. Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Plan May Disclose Your PHI

The Plan Sponsor has amended its Plan Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent in the following cases:

- **At your request.** If you request it, the Fund is required to give you access to certain PHI in order to inspect it and copy it.
- **As required by an agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

- **For treatment, payment or health care operations.** The Fund and its business associated will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:

    1. Treatment
    2. Payment, or
    3. Health care operations

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example: The Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example: The Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as “business associates.” We will also disclose enrollment information to contributing employers.

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example: The Fund may use information about your claims to refer into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund's Trustees. The Fund will also disclose PHI to the Fund Sponsor, the Board of Trustees of the Steamfitters' Industry Welfare Fund, for purposes related to treatment, payment, and health care operations, and has amended the Fund Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before (each of these includes defined exceptions under which the Fund use or disclose your PHI for these purposes without your authorization):

- Using or disclosing psychotherapy notes about you from your psychotherapist.
- **Psychotherapy notes** are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund is not likely to have access to or maintain these types of notes.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Fund receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. When required by law.

2. ***Public health purposes.*** When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. ***Court proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:

    a. the requesting party must give the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice, and

    b. the notice provided sufficient information about the proceeding to permit you to raise an objection, and

    c. No objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes***. For law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:

a. identifying or locating a suspect, fugitive, material witness or missing person, and

b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances

8. ***Determining cause of death.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties.

9. ***Funeral purposes***. When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Any other Fund uses and disclosures not described in Section 2 of this Notice will be made only if you provide the Fund with written authorization, subject to your right to revoke your authorization.

Section 3: Your Individual Privacy Rights

Breach Notification

If a breach of your unsecured PHI occurs, the Fund will notify you.

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Fund maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Fund will honor that request to the extent possible. You also may request a summary of your PHI.

Designated Record Set: Includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Fund must provide the requested information within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. You may be charged a reasonable, cost-based fee for creating or copying the PHI or preparing a summary of your PHI. Requests for access to PHI should be made to the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You should make your request to amend PHI to the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI during the six years before the date of your request. However, such accounting need not include PHI disclosures made:

To carry out treatment, payment or health care operations,

- To you about your own PHI, or
- Before the privacy rule compliance date.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order of appointment of the person as the conservator or guardian of the individual,
- An Appointment of Personal Representative form that is completed and signed by you, or
- The status of the personal representative as the parent of a minor child.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: The Plan's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices. In addition, the Fund may not (and does not) use your genetic information that is PHI for underwriting purposes. This notice is effective beginning on September 23, 2013 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

If material changes are made to this Notice, it will be posted to the Fund's website and thereafter included in the Fund's next general mailing.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with legal regulations.
- This notice does not apply to information that has been de-identified. De-identified information is information that:
- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Disclosures to the Fund Sponsor (Board of Trustees)

The "Fund Sponsor" of the Fund is The Steamfitters' Industry Welfare Fund Board of Trustees. As described in the amended Plan document, the Fund may share PHI with the Fund Sponsor (Board of Trustees) for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Fund. The Fund shares the minimum information necessary to accomplish these purposes.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or

type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You may also file a complaint with the Secretary of the U.S. Department of Health & Human Services. Filing instructions are available at: hhs.gov/ocr/privacy/hipaa/complaints/index.html.

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer at the Fund Office:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

IMPORTANT ADDITIONAL INFORMATION

The Welfare Fund is operated and controlled by a Joint Board of Trustees. The Trustees are responsible for interpreting the benefit programs, executing all contracts, amending or cancelling its provisions or benefits when they consider amendment or cancellation appropriate, and establishing whatever rules regarding the Fund's operation as they may deem necessary or appropriate. The Trustees intend to continue the Welfare Fund indefinitely but reserve the right to terminate any or all of its coverages and/or benefits at any time for any reason.

The Trustees have appointed an Executive Administrator to be responsible for the day-to-day operation of the Welfare Fund. It is the Executive Administrator who arranges for the maintenance of records, processing of claims for benefits and assists you in understanding your benefits. If you have any problems, the Fund Office will be glad to assist you.

Please understand that this is your Welfare Fund. You are encouraged to contact the Trustees or the Fund Office with any questions or comments you may have regarding benefits for you, your dependents and/or your beneficiaries.

EMPIRE EPO GUIDE [BLUE COLORED PAGES]

EPO GUIDE

Welcome!

Welcome to Empire's EPO. With Empire BlueCross BlueShield, you have access to great coverage, flexibility and all the advantages of quality care. This benefits book explains exactly how you access healthcare services, what your health plan covers and how we can help you make the most of your plan.

Important: This is not an insured benefit Plan. The benefits described in this benefit book or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Empire BlueCross BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

YOUR EPO – A SMART WAY TO GET HEALTHCARE

Your EPO, or Exclusive Provider Organization, is a group healthcare plan available to you through an insurance policy issued and underwritten by Empire BlueCross BlueShield. The EPO offers a network of healthcare providers available to you through Empire. If you think about your town, it includes doctors, hospitals, laboratories and other medical facilities that provide healthcare services–that's what we mean by healthcare "providers." Some healthcare providers contract with health plans like Empire to provide services to members as part of the plan's "network."
With Empire's EPO, when you need healthcare services, you are free to get care from any provider participating in Empire's network.

WHAT'S THE EMPIRE EPO ADVANTAGE?

When you use Empire's EPO network to access healthcare, you get:

- A comprehensive Web site, *www.empireblue.com* for fast, personalized, secure information
- Among the largest network of doctors and hospitals in New York State
- Providers that are continuously reviewed for Empire's high standards of quality
- Minimal out-of-pocket costs for behavioral healthcare and a wide variety of hospital and medical services when you stay in-network
- Easy to use – no claim forms to file when you stay in-network
- Coverage for you and your family when traveling or temporarily living outside of Empire's service area

HOW TO USE THIS GUIDE

This Guide gives you an overview of the features and benefits of your plan. Use it as a reference to find out what's covered, what your costs are, and how to get healthcare services any time you or a covered family member need them.*

You'll find the information you need divided into sections. Here's a quick reference:

IF YOU ARE LOOKING FOR …	YOU'LL FIND IT IN	ON PAGE
• HOW THE PLAN WORKS	USING YOUR EPO	8
• WHAT'S COVERED	COVERAGE	19
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	38
• HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	48

* *This Guide describes only the highlights of your medical coverage. It does not attempt to cover all the details. Additional details are provided in the plan documents and insurance and/or service contracts, which legally govern the plan. In the event of any discrepancy between this Guide and the plan documents, the plan documents will govern.*

OUR ROLE IN NOTIFYING YOU

There may be times when benefits and/or procedures may change. We or your employer will notify you of any change in writing. Announcements will go directly to you at the address that appears on our records or to your group benefits office.

CONFORMITY WITH LAW

Any term of this Booklet which is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.

Manage Your Healthcare Online!

REGISTER NOW TO DO IT ON THE WEB!

Go to *www.empireblue.com* where you can securely manage your health plan 24 hours a day, 7 days a week. Here's what you can do:

- Check status of claims
- Search for doctors and specialists
- Update your member profile
- Get health information and tools with My Health powered by WebMD
- Print plan documents
- Receive information through your personal "Message Center"

Plus much more …

HERE'S WHAT YOU'LL NEED TO DO

All members of your family 18 or older must register separately:

- Go to *www.empireblue.com*
- Click on the Member tab and choose "Register"
- Follow the simple registration instructions

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

Click on MY HEALTH from your secure homepage after you register to receive the following features:

- Take the *Health IQ* test and compare your score to others in your age group
- Find out how to improve your score – *and your health* – online
- Find out how to take action against chronic and serious illnesses

Get health information for you and your family.

YOUR PRIVACY IS PROTECTED

Your information is protected by one of the most advanced security methods available.

Register today to experience hassle-free service!
www.empireblue.com

Your EPO Guide

Introduction

Getting Answers Your Way

Empire gives you more choices for contacting us with your customer service questions. Use the Internet, phone or mail to get the information you need, when you need it.

ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit *www.empireblue.com*. At Empire, we understand that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially. Nervous about using your PC for important healthcare questions or transactions? We've addressed that too! Just "click to talk" to a representative or send us an e-mail.

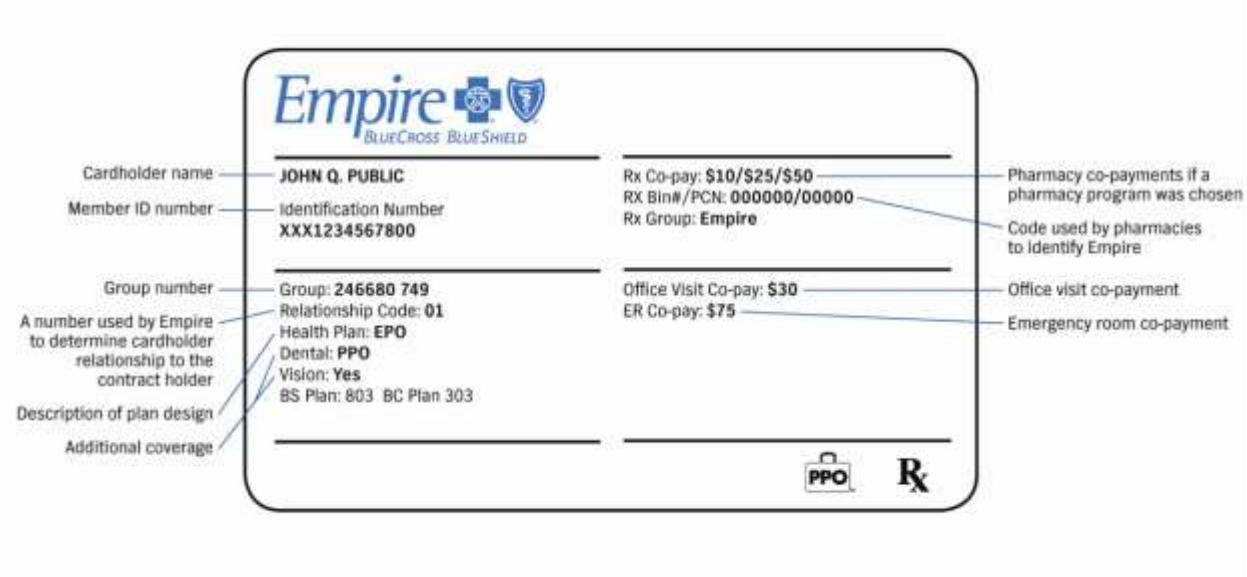
BY TELEPHONE

MEMBER SERVICES	For questions about your benefits, claims or membership To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	**1-844-243-5566** TDD for hearing impaired: **1-800-241-6894** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a EPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** *www.bcbs.com* 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain treatments and procedures.	**1-800-982-8089** 8:30 a.m. to 5:00 p.m. Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
FRAUD HOTLINE	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

Empire BlueCross BlueShield
EPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Your Identification Card

Empire has created an identification card to make accessing your healthcare as easy as possible. The Empire BlueCross BlueShield I.D. card is a single card that you can use for all your Empire health insurance services, as it shows each of the plans or programs you're enrolled in. Always carry it and show it each time you receive healthcare services. Every covered member of your family will get their own card. The information on your card includes your name, identification number, and various co-payment amounts. Below is an example of an Empire ID card.



To make it easier for you to use your card, following are answers to some frequently asked questions:

Q: *Why is Empire issuing this kind of I.D. card?*

A: Empire's card has all the information providers need to know to serve our members' healthcare needs. Our design eliminates the need for you to carry multiple cards.

Q: *Why does each family member get a separate I.D. card?*

A: By giving your family members their own card with their own name on it, providers know right away that each family member is covered by the plan – even dependents. If someone in your family happens to forget the card, he or she can still use another family member's card. (In a few instances, family members in some groups will receive two I.D. cards in the member's name only. These cards will be used for all family members.)

Q: *How can I replace a lost I.D. card?*

A: Visit *www.empireblue.com* or call Member Services. By visiting us on-line, you can also print a temporary identification card for your immediate use.

Using Your EPO

Know the Basics

USE YOUR EPO TO YOUR BEST ADVANTAGE

Your health is valuable. Knowing how to use your EPO to your best advantage will help ensure that you receive high quality healthcare – with maximum benefits. Here are three ways to get the most from your coverage.

- BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN. That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the plan applies to certain types of care.
- PLEASE REMEMBER TO PRECERTIFY hospital admissions and certain treatments and procedures. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.
- ASK QUESTIONS about your healthcare options and coverage. To find answers, you can:

– Read this Guide.

– Call Member Services when you have questions about your EPO benefits in general or your benefits for a specific medical service or supply.

– Call *24/7 NurseLineand AudioHealth Library* – available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.

Talk to your provider about your care, learn about your benefits and your options, and ask questions. Empire is here to work with you and your provider to see that you get the best benefits while receiving the quality healthcare you need.

The key to using your EPO plan is understanding how benefits are paid. To receive benefits, you must use a provider in the Empire network or one covered through the BlueCard PPO Program. There are no out-of-network benefits under this program.

You can view and print up-to-date information about your plan or request that information be mailed to you by visiting *www.empireblue.com*.

IN-NETWORK SERVICES

In-network services are healthcare services provided by a doctor, hospital or healthcare facility that has been selected by Empire or another Blue Cross and/or Blue Shield plan to provide care to our EPO members. With in-network care, you get these advantages:

- CHOICE – You can choose any participating provider from the largest network of doctors and hospitals in New York State or across the country from providers participating in the BlueCard PPO® network through local Blue Cross and Blue Shield plans.
- FREEDOM – You do not need a referral to see a specialist, so you direct your care.
- LOW COST – Benefits are paid after a co-payment/or deductible and coinsurance payment for office visits and many other services.
- BROAD COVERAGE – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home healthcare.
- CONVENIENCE – Usually, there are no claim forms to file.

Here's an example of how in-network works.

	IN-NETWORK
ANNUAL DEDUCTIBLE*	$0
CO-PAYMENT (for office visits and certain covered services)	$20 per visit
CO-PAYMENT (for hospital inpatient admissions)	$0
CO-PAYMENT (for emergency room)	$100 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	N/A
ANNUAL OUT-OF-POCKET LIMIT	$4,900/Individual $9,900/Family
LIFETIME MAXIMUM	Unlimited

How to Access Primary and Specialty Care Services

Your health plan covers certain primary and specialty care services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

To make an appointment call your physician's office:

- Tell them you are an Empire member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

When You Need Care After Normal Office Hours

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

Inter-Plan Programs

Out-of-Area Services

Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Empire's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Empire and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Empire's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other

* *If you had group coverage under a major medical or extended medical plan either with Empire or another carrier prior to your PPO effective date, we will apply any deductible met under that prior contract in the same calendar year to your PPO deductible. For services rendered in October, November or December, deductible credit will be applied to the following year's deductible.*

geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Empire's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Empire's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Empire's Service Area

Your Liability Calculation

When covered healthcare services are provided outside of Empire's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, Empire may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Empire will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the covered services as set forth in this paragraph.

BLUECARD® PPO PROGRAM

Care When you are Out of Our Service Area Within the U.S.

If you are traveling outside the Empire service area, the BlueCard® PPO program lets you use other Blue Cross and/or Blue Shield plans' PPO networks of physicians, hospitals and other health care providers. As an EPO member, you are automatically enrolled in the BlueCard® PPO program. This allows you to receive in-network benefits across the country outside of our network area from providers participating with other Blue Plans' PPO networks. As long as these services are covered services under your Contract or Certificate, they will be treated as in-network services. If you are traveling and need medical care, call 1-800-810-BLUE (2583), for the names and addresses of the PPO providers nearest you. You may also visit the Blue Cross and Blue Shield Association Web site to locate providers in other states at www.bcbs.com.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides hospital and professional coverage through an international network of healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®[1] Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the after: maximum allowed amount.

Your Benefits at a Glance

Empire's EPO provides a broad range of benefits to you and your family. Following is a brief overview of your coverage.

Some services require precertification with Empire's Medical Management Program. See the Health Management section for details

	YOU PAY
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**
HOME/OFFICE VISITS	$20 co-payment per visit
SPECIALIST VISITS	$20 co-payment per visit
ONLINE VISITS	$20 co-payment per visit
CHIROPRACTIC CARE	$20 co-payment per visit
SECOND OR THIRD SURGICAL OPINION	$20 co-payment per visit
DIABETES EDUCATION AND MANAGEMENT	$20 co-payment per visit
ALLERGY TESTING and TREATMENT	$20 co-payment per visit (co-payment waived for treatment)
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy • MRIs/MRAs • Nuclear cardiology services • PET/CAT scans • Laboratory tests	 $0 $0 $0 $0 $0 $0
SURGERY	$0
PRE-SURGICAL TESTING	$0
ANESTHESIA	$0
CHEMOTHERAPY, RADIATION	$0
KIDNEY DIALYSIS	$0
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0
SURGERY (Inpatient and Outpatient) **	$0
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$20 co-payment per visit
CARDIAC REHABILITATION	$20 co-payment per outpatient visit

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

** *For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher maximum allowed amount. For a second procedure done through a separate incision, Empire will pay the maximum allowed amount for the procedure with the higher allowance and up to 50% of the maximum allowed amount for the other procedure.*

	YOU PAY
PREVENTIVE CARE	**IN-NETWORK**
ANNUAL PHYSICAL EXAM • One per calendar year	$0
SCREENING TESTS (covered preventive screenings) • Cholesterol (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test – Sigmoidoscopy • Routine Prostate Specific Antigen (PSA) in asymptomatic males • Diagnostic PSA	$0 $0 $0 $0 $0
WELL-WOMAN CARE • Office visits • Pap smears • Bone Density testing and treatment • Mammogram • Women's sterilization procedures and counseling • Breastfeeding support, supplies and counseling – One breast pump per pregnancy • Screenings and/or counseling for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections STIs), Human immune deficiency (HIV), interpersonal and domestic violence.	$0 $0 $0 $0 $0 $0 $0
WELL-CHILD CARE • In-hospital visits • Office visits • Lab tests ordered at the well-child visits and performed in the office or in the laboratory • Certain immunizations (office visits are not required)	$0 $0 $0 $0

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY
EMERGENCY AND URGENT CARE	**IN-NETWORK**
EMERGENCY ROOM (Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing)	$100 per visit co-payment (waived if admitted to the same hospital within 24 hours)
PHYSICIAN'S OFFICE	$20 co-payment per visit
URGENT CARE SERVICES	$20 co-payment per visit
EMERGENCY LAND AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the maximum allowed amount
MATERNITY CARE	**IN-NETWORK**
PRENATAL AND POSTNATAL CARE (In doctor's office)	$0
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0
ROUTINE NEWBORN NURSERY CARE (In hospital)	$0
OBSTETRICAL CARE (In hospital)	$0
OBSTETRICAL CARE (In birthing center)	$0

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY
HOSPITAL SERVICES*	**IN-NETWORK**
SEMI-PRIVATE ROOM AND BOARD	$0
ANESTHESIA AND OXYGEN	$0
CHEMOTHERAPY AND RADIATION THERAPY	$0
DIAGNOSTIC X-RAYS AND LAB TESTS	$0
DRUGS AND DRESSINGS	$0
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0
INTENSIVE CARE	$0
KIDNEY DIALYSIS	$0
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0
SURGERY (Inpatient and Outpatient) **	$0

* *Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation.*

** *For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher maximum allowed amount. For a second procedure done through a separate incision, Empire will pay the maximum allowed amount for the procedure with the higher allowance and up to 50% of the maximum allowed amount for the other procedure.*

	YOU PAY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor)	$0
ORTHOTICS	$0
PROSTHETICS (i.e. artificial arms, legs, eyes, ears)	$0
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	$0
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	$0
ASSISTIVE COMMUNICATION DEVICES (for the treatment of Autism Spectrum Disorder)	$20 co-payment
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**
SKILLED NURSING FACILITY Up to 120 days per calendar year	$0
HOSPICE Unlimited Days per lifetime	$0
HOME HEALTH CARE	**IN-NETWORK**
HOME HEALTH CARE Up to 200 visits per calendar year (a visit equals 4 hours of care) **	$0
HOME INFUSION THERAPY	$0
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**
PHYSICAL THERAPY AND REHABILITATION • Up to 30 days of inpatient service per calendar year • Up to 60 visits combined in home, office or outpatient facility per calendar year	$0 $20 co-payment per visit
OCCUPATIONAL, SPEECH, VISION THERAPY • Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$20 co-payment per visit

	YOU PAY
MENTAL HEALTH CARE	**IN-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits	**Outpatient Facility** $0 **Outpatient Office** $20 co-payment
INPATIENT • Unlimited number of medically necessary days • Unlimited number of medically necessary visits from mental healthcare professionals	$0 $0
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits, including visits for family counseling	**Outpatient Facility** $0 **Outpatient Office** $20 co-payment
INPATIENT • Unlimited number of medically necessary days of detoxification • Unlimited number of medically necessary rehabilitation days	$0 $0

Coverage

Doctor's Services

When you need to visit your doctor or a specialist, Empire makes it easy. In-network, you pay only a small co-payment. There are no claim forms to fill out for X-rays, blood tests or other diagnostic procedures – as long as they are requested by the doctor and done in the doctor's office or a network facility. For in-network allergy testing, there is only a small co-payment. In-network visits for ongoing allergy treatment are covered in full.

Tips For Visiting Your Doctor

- When you make your appointment, confirm that the doctor is an Empire network provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to an outside lab or radiologist for tests or X-rays, call Member Services to confirm that the supplier is in Empire's network. This will ensure that you receive maximum benefits.

Ask about a second opinion anytime that you are unsure about surgery or a cancer diagnosis. Second and third opinions for surgery are paid in full when arranged through Empire's Medical Management Program. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the in-network level, even if you use an out-of-network specialist, as long as your participating doctor provides a written referral to a non-participating specialist.

ONLINE VISITS

Your coverage includes online physician office visits. Covered Services include a medical consultation using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed primary care physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

Online visits are not meant for the following purposes:

1. To get reports of normal lab or other test results;
2. To request an office appointment;
3. To ask billing, insurance coverage or payment questions;
4. To ask for a referral to a specialist Doctor;
5. To request precertification for a benefit under your health Plan; or
6. To ask the physician to consult with another physician.

You must have the following computer hardware in order for the online website to work properly: USB or built in webcam (to enable two-way video during web conversations); and audio functionality. To minimize audio feedback, use a headset or headphones with a built-in microphone. To begin the online visit, log on to www.livehealthonline.com and establish an online account by providing some basic information about you and your insurance plan. Before you connect to a Doctor, you will be asked: the kind of condition you want to discuss with the Doctor, list your local pharmacy, provide information for the credit card you want your cost share for the visit to be billed to, agree to the terms of use, and select an available physician. If you are not in New York State when you seek an online visit, you will need to check to be sure an online Doctor is available in the state you are in because online Doctors are not available in every state.

The visit with the physician will not start until you provide the above information and click "connect." The visit will be documented in an electronic health record. You may access your records and print them, and may email or fax them to your primary care physician.

CLINICAL TRIALS

We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this booklet.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this benefit plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

WOMAN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This federal law applies to almost all health care plans, except Medicare Supplement and Medicare Risk plans, as of plan years beginning on or after October 21, 1998. The law imposes certain requirements on employee benefit plans and health insurers that provide medical and surgical benefits with respect to a mastectomy. Specifically, in the case of a participant or beneficiary who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the law requires coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

The coverage described above shall be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to all coverage terms and limitations (for example, Deductibles and Coinsurance) consistent with those established for other benefits under the plan.

What's Covered

Covered services are listed in *Your Benefits at a Glance* section. Following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury

  This includes the Specialist e-Consultations Program. If Your Participating Provider is in Our Cooperative Care program and is rendering primary care services to You, he or she may request an electronic consultation with a Specialist to help evaluate Your condition or diagnosis. The electronic consultation will be provided by a Participating Provider who has agreed to participate in Our "e-consultation" program and will be selected by Your Participating Provider in his or her clinical judgement. The electronic consultation will be at no cost to You. Your Participating Provider may consider the information provided by the Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies such as secure web- based email, fax and/or exchange of electronic medical records. The results may be documented in an electronic health record.

- Diabetes supplies prescribed by an authorized provider:
  - Blood glucose monitors, including monitors for the legally blind
  - Testing strips
  - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
  - Oral agents for controlling blood sugar
  - Other equipment and supplies required by the New York State Health Department
  - Data management systems

- Diabetes self-management education and diet information, including:

  - Education by a physician, certified nurse practitioner or member of their staff:
    - At the time of diagnosis
    - When the patient's condition changes significantly

- When medically necessary

- Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
- Home visits for education when medically necessary

- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Medically necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Chiropractic care

We will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of Autism Spectrum Disorder:

- **Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has Autism Spectrum Disorder.
- **Behavioral health treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual when provided by a licensed provider. We will provide such coverage when provided by a licensed provider. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments (over the duration of the intervention) in objective and measurable terms.
- **Applied Behavior Analysis (ABA).** We will provide coverage for Applied Behavior Analysis, when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education.
- **Psychiatric and Psychological care.** We will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.
- **Therapeutic care.** We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat Autism Spectrum Disorder and when the services provided by such providers are otherwise covered under this Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Plan.
- **Assistive communication devices (ACDs).** We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items such as, but not limited to, laptops, desktops, or tablet computers. We will cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

  Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per covered device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that

are not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance.

We will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

Please refer to the Health Management section for details regarding precertification requirements.

What's Not Covered

The following medical services are not covered:

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
- Orthotics for treatment of routine foot care
- Routine vision care
- Routine hearing exams
- Hearing aids and the examination for their fitting
- Services such as laboratory, X-ray and imaging, and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship
- Services given by an unlicensed provider or performed outside the scope of the provider's license

Emergency and Urgent Care

IF YOU NEED EMERGENCY CARE

Should you need emergency care, your plan is there to cover you. Emergency care is covered in the hospital emergency room.

To be covered as emergency care, the condition must be a medical or behavioral 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:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

2. Serious impairment to such person's bodily functions;

3. Serious dysfunction of any bodily organ or part of such person; or

4. Serious disfigurement of such person.

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call 24/7 NurseLine at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's PPO network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same co-payment as for an office visit.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

Remember: You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

Tips For Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment.
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

Please refer to the Health Management section for details regarding precertification requirements.

What's Not Covered

These emergency services are not covered:

- Use of the Emergency Room:
  - To treat routine ailments
  - Because you have no regular physician
  - Because it is late at night (and the need for treatment is not sudden and serious)

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include: X-ray services; Care for broken bones; Tests such as flu, urinalysis, pregnancy test, rapid strep; Laboratory services; Stitches for simple cuts; and Draining an abscess.

Covered Urgent Care Services can be received in a Doctor's office, an Urgent Care Facility or an Outpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Your Benefits At A Glance" section for more details on how benefits vary in each setting.

An Urgent Care Facility is a licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care Services.

Emergency Air Ambulance

We will provide in-network coverage for air ambulance services when needed to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care, subject to cost sharing obligations, when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health
- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for your treatment as determined by Empire, and use of land ambulance would pose an immediate threat to your health

If Empire determines that the condition for coverage for air ambulance services have not been met but your condition did require transportation by land ambulance to the nearest acute care hospital, Empire will only pay up to the maximum allowed amount that would be paid for land ambulance to that hospital.

Emergency Land Ambulance

We will provide coverage for land ambulance transportation to the nearest acute care hospital, in connection with emergency room care or emergency inpatient admission, provided by an ambulance service, when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in

- placing the member's health afflicted with a condition in serious jeopardy, or for behavioral condition, place the health of a member or others in serious jeopardy; or
- serious impairment to a person's bodily functions,
- serious dysfunction of any bodily organ or part of a person; or
- serious disfigurement to the member.

Non-Emergency Ambulance Transportation

We cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To amore cost-effective Acute care Facility; or
- From an Acute Facility to a sub-Acute setting.

Limitations/Terms of Coverage

- We do not cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by us, even though prescribed by a Physician.
- We do not cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:
  - The point of pick-up is inaccessible by land vehicle; or
  - Great distances or other obstacles (for example, heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

Maternity Care

IF YOU ARE HAVING A BABY

There are no out-of-pocket expenses after the initial office visit co-payment for maternity and newborn care when you use in-network providers. That means you do not need to continue to pay a co-payment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the hospital or birthing center, as well as routine newborn nursery care are all covered 100% in-network.

Please refer to the Health Management section for details regarding precertification requirements.

FUTURE MOMS PROGRAM

Empire understands that having a baby is an important and exciting time in your life, so we developed the Future Moms Program. Specially trained obstetrical nurses, working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth. And just as important, we're here to answer your questions.

While most pregnancies end successfully with a healthy mother and baby, Empire's Future Moms Program is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies. We can also provide home health care referrals and health education counseling.

Please let us know as soon as you know that you're pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in the Future Moms Program. Call 1-800-845-4742 and listen for the prompt that says "pre-certify." You will be transferred to the Future Moms Program.

Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.

What's Covered

Covered services are listed in *Your Benefits At A Glance* section. Following are additional covered services and limitations:

- One home care visit fully covered by Empire if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this timeframe. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.
- Parent education, and assistance and training in breast or bottle feeding, if available
- Circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother.
- Semi-private room

Please refer to the Health Management section for details regarding precertification requirements.

What's Not Covered

These maternity care services are not covered:

- Days in hospital that are not medically necessary (beyond the 48-hour/96-hour limits)
- Services that are not medically necessary
- Private room
- Out-of-network birthing center facilities
- Private duty nursing

REMEMBER	**Use a network obstetrician/gynecologist to receive the lowest cost maternity care.**

NEWBORNS' AND MOTHERS' HEALTH PROCTECTION ACT OF 1996

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 Program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

INFERTILITY TREATMENT

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations.

What's Covered

Medical and surgical procedures, such as

- Intrauterine insemination (IUI) and
- Dilation and curettage (D&C), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility; and services in relation to diagnostic tests and procedures necessary
- To determine infertility, or
- In connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:

  - hysterosalpingogram
  - hysteroscopy
  - endometrial biopsy
  - laparoscopy
  - sono hysterorgram
  - post-coital tests
  - testis biopsy
  - semen analysis
  - blood tests
  - ultrasound and
  - other medically necessary diagnostic tests and procedures, unless excluded by law.

Services must be medically necessary and must be received from eligible providers as determined by Empire in accordance with applicable regulations of the New York State Insurance Department. In general, an eligible provider is defined as a healthcare provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

If you have prescription drug coverage, then prescription drugs approved by the FDA specifically for the diagnosis and reatment of infertility that are not related to any excluded services are covered, subject to all the conditions, exclusions, limitations and requirements that apply to all other prescription drugs under this plan.

What's Not Covered

We will not cover any services related to or in connection with:

- Artificial insemination
- In-vitro fertilization (IVF)
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Reversal of elective sterilizations, including vasectomies and tubal ligations
- Sex-change procedures
- Cloning
- Medical or surgical services or procedures that are experimental
- Services to diagnose or treat infertility if we determine, in our sole judgment, that the service was not medically necessary.

For members covered under this group plan, the new contract a member may convert to after termination of coverage may not contain these infertility benefits.

Hospital Services

IF YOU VISIT THE HOSPITAL

Your plan covers most of the cost of your medically necessary care when you stay at a network hospital for surgery or treatment of illness or injury. No benefits are available when you use an out-of-network provider.

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or medically necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

Please refer to the Health Management section for details regarding precertification requirements.

Tips For Getting Hospital Care

- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Inpatient And Outpatient Hospital Care

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration
- Anesthesiologist, including one consultation before surgery and services during and after surgery
- Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, PET/CAT scans and nuclear cardiology services

Please refer to the Health Management section for details regarding precertification requirements

Inpatient Hospital Care

What's Covered

Following are additional covered services for inpatient care:

- Semi-private room and board when
  - The patient is under the care of a physician, and
  - A hospital stay is medically necessary.
- Coverage is for unlimited days unless otherwise specified
- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital
- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery
  - Surgery on the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.

- Use of cardiographic equipment
- Drugs, dressings and other medically necessary supplies
- Social, psychological and pastoral services
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery
- Reconstructive surgery for a functional defect which is present from birth
- Physical, occupational, speech and vision therapy including facilities, services, supplies and equipment
- Facilities, services, supplies and equipment related to medically necessary medical care
- Residential treatment services

Please refer to the Health Management section for details regarding precertification requirements.

Outpatient Hospital Care

What's Covered

Following are additional covered services for same-day care:

- Same-day and hospital outpatient surgical facilities
- Surgeons
- Surgical assistant if:
  - None is available in the hospital or facility where the surgery is performed, and
  - The surgical assistant is not a hospital employee
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered
  - In a hospital-based or free-standing facility. See "hospital/facility" in the Definitions section.

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

- Private duty nursing
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room. The additional cost cannot be applied to your deductible or coinsurance.
- 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
- Services performed in the following:
  - Nursing or convalescent homes
  - Institutions primarily for rest or for the aged
  - Rehabilitation facilities (except for physical therapy)
  - Spas
  - Sanitariums
  - Infirmaries at schools, colleges or camps
- Any part of a hospital stay that is primarily custodial
- Elective cosmetic surgery or any related complications
- Hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility. See "hospital/facility" in the Details and Definitions section.

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

- Same-day surgery not pre-certified as medically necessary by Empire's Medical Management Program
- Routine medical care including but not limited to:
  - Inoculation or vaccination
  - Drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow

Durable Medical Equipment and Supplies

IF YOU NEED EQUIPMENT OR MEDICAL SUPPLIES

Your EPO covers the cost of medically necessary prosthetics, orthotics and durable medical equipment and medical supplies from network suppliers only. Out-of-network benefits are not available. Benefits and plan maximums are shown in *Your Benefits At A Glance* section.

Please refer to the Health Management section for details regarding precertification requirements.

An Empire network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-844-243-5566.

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available. If you have prescription drug coverage with Empire's pharmacy program, you may order these formulas or supplements through Empire's pharmacy program. Benefits and plan maximums are shown in *Your Benefits At A Glance* section.

Your plan covers the cost of medically necessary prosthetics, orthotics and durable medical equipment from network suppliers

Tip For Obtaining Special Medical Supplies

For prosthetics, orthotics and durable medical equipment, be sure the network vendor knows the number to call for Medical Management precertification.

What's Covered

Covered services are listed in Your *Benefits At A Glance* section. Following are additional covered services and limitations:

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
  - Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
  - Prescription lenses, if organic lens is lacking
  - Supportive devices essential to the use of an artificial limb
  - Corrective braces
  - Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors
- Rental (or purchase when more economical) of medically necessary durable medical equipment
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician
- Reasonable cost of repairs and maintenance for covered medical equipment
- Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:
  - The formula is medically necessary and effective, and
  - Without the formula, the patient would become malnourished, suffer from serious physical disorders or die.
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare provider must provide a written order.

What's Not Covered

The following equipment is not covered

- Air conditioners or purifiers
- Humidifiers or dehumidifiers
- Exercise equipment
- Swimming pools
- False teeth
- Hearing aids

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

You receive coverage through Empire's EPO for inpatient care in a skilled nursing facility or hospice. Benefits are available for network facilities only.

Please refer to the Health Management section for details regarding precertification requirements.

Skilled Nursing Care

What's Covered

You are covered for inpatient care in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. The number of covered days is listed in Your *Benefits at a Glance* section. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor provides:
  - A referral and written treatment plan,
  - A projected length of stay,
  - An explanation of the services the patient needs, and
  - The intended benefits of care.
- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other healthcare professional.

What's Not Covered

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
  - Gives assistance with daily living activities
  - Is for rest or for the aged
  - Treats drug addiction or alcoholism
  - Convalescent care
  - Sanitarium-type care
  - Rest cures

Hospice Care

Hospice Care is available if Your primary attending Physician has certified that You have twelve (12) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is limited to the number of days indicated on the Schedule of Benefits section of this Booklet. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located.

We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker or caretaker care

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations:

- Hospice care services, including:
  - Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
  - Medical care given by the hospice doctor
  - Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference
  - Physical, occupational, speech and respiratory therapy when required for control of symptoms
  - Laboratory tests, X-rays, chemotherapy and radiation therapy
  - Social and counseling services for the patient's family, including bereavement counseling visits until one year after death
  - Transportation between home and hospital or hospice when medically necessary
  - Medical supplies and rental of durable medical equipment
  - Up to 14 hours of respite care in any week

Tips for Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility, ask your doctor or caseworker to see the Health Facilities directory.
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

Home Health Care

IF YOU NEED HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage for home health care and home infusion therapy when you use an in-network provider. Benefits and plan maximums are shown in *Your Benefits At A Glance* section

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network.

What's Covered

Covered services are listed in *Your Benefits At A Glance* section. Following are additional covered services and limitations:

- Up to 200 home health care visits per year. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Part-time home health aide services (skilled nursing care)
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a doctor
  - Laboratory tests

What's Not Covered

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care
- Out-of-network home infusion therapy

Physical, Occupational, Speech or Vision Therapy

IF YOU NEED THERAPY

You receive benefits through Empire's EPO for outpatient physical, occupational, speech and vision therapy by a network provider. There are no benefits for out-of-network services.

Please refer to the Health Management section for details regarding precertification requirements.

Tip for Receiving Therapy

- Ask for exercises you can do at home that will help you get better faster.

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations:

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an inpatient or outpatient basis up to the plan maximums if:
  - Prescribed by a physician,
  - Designed to improve or restore physical functioning within a reasonable period of time, and

Outpatient care must be given at home, in a therapist's office or in an outpatient facility by an in-network provider; inpatient therapy must be short-term.

- Occupational, speech or vision therapy, or any combination of these on an outpatient basis up to the plan maximums if:
  - Prescribed by a physician or in conjunction with a physician's services
  - Given by skilled medical personnel at home, in a therapist's office or in an outpatient facility,
  - Performed by a licensed speech/language pathologist or audiologist, and

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities
- Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy

Behavioral Healthcare

IF YOU NEED BEHAVIORAL HEALTHCARE

At Empire we realize that your mental health is as important as your physical health. That's why we include behavioral health benefits at little out-of-pocket cost. Your behavioral healthcare benefits cover outpatient treatment for alcohol or substance abuse, inpatient detoxification, inpatient alcohol and substance abuse rehabilitation and inpatient and outpatient mental health care from network providers only. You will not receive benefits for any of these services if you go out-of-network.

Please refer to the Health Management section for details regarding precertification requirements.

Mental Health Care

What's Covered

In addition to the services listed in Your *Benefits at a Glance* section, the following mental health care service is covered:

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management.
- Care from psychiatrists, psychologists, nurse practitioners or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.
- Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law.
- We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges.

What's Not Covered

The following mental health care services are not covered:

- Care that is not medically necessary

Treatment for Alcohol or Substance Abuse

What's Covered

In addition to the services listed in *Your Benefits At A Glance* section, the following services are covered:

- Family counseling services for alcohol or substance abuse at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive medically necessary counseling visits.
- Residential treatment services

What's Not Covered

The following alcohol and substance abuse treatment services are not covered:

- Care that is not medically necessary

Exclusions and Limitations

EXCLUSIONS

In addition to services mentioned under "What's Not Covered" in the prior sections, your plan does not cover the following:

Dental Services

- Dental services, including but not limited to:
  - Cavities and extractions
  - Care of gums
  - Bones supporting the teeth or periodontal abscess
  - Orthodontia
  - False teeth
  - Treatment of TMJ that is dental in nature
  - Orthognathic surgery that is dental in nature

However, your plan does cover:

- Surgical removal of impacted teeth
- Treatment of sound natural teeth injured by accident if treated within 12 months of the injury

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:
  - Experimental or investigative
  - Obsolete or ineffective
- Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:
  - Not of proven benefit
  - Not generally recognized by the medical community (as reflected in published medical 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 a covered person's condition. Empire 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:

- (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 review 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).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.
- Gene Therapy

However, your plan will cover an experimental or investigational treatment approved by an External Appeal agent certified by the state. *Refer to the Complaints, Appeals and Grievances Section.*

Government Services

- Services covered under government programs, except Medicaid or where otherwise noted
- Government hospital services, except:
  - Specific services covered in a special agreement between Empire and a government hospital
  - United States Veterans' Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.

Home Care

- Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency.

Inappropriate Billing

- Services usually given without charge, even if charges are billed
- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified

Not Medically Necessary Transgender Surgery

- Surgery and/or treatment for gender change that does not meet our medical criteria for medical necessity.

Miscellaneous

- Surgery and/or treatment for gender change that does not meet our medical criteria for medical necessity.

Prescription Drugs

- All prescription drugs and over the counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated.

Reproductive Technologies/ Sterilization

- Reversal of sterilization
- Assisted reproductive technologies including but not limited to
  - In-vitro fertilization
  - Artificial insemination
  - Gamete and zygote intrafallopian tube transfer
  - Intracytoplasmic sperm injection

Travel

- Travel, even if associated with treatment and recommended by a doctor

Vision Care

- Eyeglasses, contact lenses, LASIK surgery and the examination for their fitting except following cataract surgery, unless specifically indicated

War

- Services for illness or injury received as a result of war

Workers' Compensation

- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs

LIMITATION AS INDEPENDENT CONTRACTOR

The relationship between Empire BlueCross BlueShield and hospitals, facilities or providers is that of independent contractors. Nothing in this contract shall be deemed to create between Empire and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Empire will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

Health Management

Empire's Medical Management Program

Managing your health includes getting the information you need to make informed decisions, and making sure you get the maximum benefits the plan will pay. To help you manage your health, Empire provides the Empire's Medical Management Program, a service that pre-certifies hospital admissions and certain treatments and procedures, to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

Empire's Medical Management Program works with you and your provider to help confirm the medical necessity of services and help you make sound health care decisions. The program helps ensure that you and your family members receive the highest quality of care at the right time, in the most appropriate setting.

You can contact our Medical Management program by calling the Member Services telephone number located on the back of your identification card.

Empire may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Empire's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services. In addition, we may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your Claim from medical review if certain conditions apply. Just because Empire exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Empire will do so in the future, or will do so in the future for any other Provider, Claim or Member. Empire may stop or modify any such exemption with or without advance notice. You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory or contacting customer service number on the back of your ID card.

How Empire's Medical Management Program Helps You

To help ensure that you receive the maximum coverage available to you, Empire's Medical Management Program

- Reviews all planned and emergency hospital admissions.
- Reviews ongoing hospitalization.
- Performs case management.
- Coordinates discharge planning.
- Coordinates purchase and replacement of durable medical equipment, prosthetics and orthotic requirements.
- Reviews inpatient and ambulatory surgery.
- Reviews high-risk maternity admissions.
- Reviews care in a hospice or skilled nursing or other facility.

All other services will be subject to retrospective review by our Medical Management team to determine medical necessity.

The following health care services must be pre-certified with Empire's Medical Management Program.

CALL TO PRECERTIFY THE REQUIRED SERVICE
FOR ALL HOSPITAL ADMISSIONS • At least two weeks prior to any planned surgery or hospital admission • Within 48 hours of an emergency hospital admission, or as soon as reasonably possible • Of newborns for illness or injury • Before you are admitted to a rehabilitation facility or a skilled nursing facility
MATERNITY CARE • As soon as reasonably possible; we request notification within the first three months of pregnancy when possible • Within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth.
BEFORE YOU RECEIVE/USE □ All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns; □ Inpatient Mental Health Care, Substance Use Services; □ Mental Health and Substance Use Intensive Outpatient Program Services; □ Mental Health and Substance Use Partial Hospitalization Program Services; □ Occupational, physical, speech and vision therapy □ Outpatient/Ambulatory Surgical Treatments; □ Diagnostic Radiology Services; □ Therapeutic Radiology Services; □ Advanced Imaging Services □ Durable Medical Equipment; □ Prosthetics and Orthotics; □ Air ambulance □ Autism Spectrum Disorder

IF SERVICES ARE NOT PRECERTIFIED

If you call to pre-certify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure. This benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not medically necessary, no benefits will be paid.

INITIAL DECISIONS

Empire will comply with the following time frames in processing precertification, concurrent and retrospective review of requests for services.

a. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of the request.

If We need additional information, We will request it within fifteen (15) calendar days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period allowed to submit the additional information.

b. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

c. Court Ordered Treatment. With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

CONCURRENT REVIEWS

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

   If We need additional information, We will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider within 24 hours of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

RETROSPECTIVE REVIEWS

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

RETROSPECTIVE REVIEW OF PREAUTHORIZED SERVICES

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;

- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

RECONSIDERATION

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider and in writing.

New Medical Technology

REQUESTING COVERAGE

Empire uses a committee composed of Empire Medical Directors, who are doctors, and participating network physicians to continuously evaluate new medical technology that has not yet been designated as a covered service. If you want to request certification of a new medical technology before beginning treatment, your provider must contact Empire's Medical Management Program. The provider will be asked to do the following:

- Provide full supporting documentation about the new medical technology
- Explain how standard medical treatment has been ineffective or would be medically inappropriate
- Send us scientific peer reviewed literature that supports the effectiveness of this particular technology. The literature must not be in the form of an abstract or individual case study.

Empire's staff will evaluate the proposal in light of your contract and Empire's current medical policy. Empire will then review the proposal, taking into account relevant medical literature, including current peer review articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will send all decisions to the member and/or provider.

Case Management

IF YOU NEED ADDITIONAL SUPPORT FOR SERIOUS ILLNESS

The Medical Management Program's Case Management staff can provide assistance and support when you or a member of your family faces a chronic or catastrophic illness or injury. Empire's nurses can help you and your family:

- Find appropriate, cost-effective healthcare options
- Reduce medical cost
- Assure quality medical care

A Case Manager serves as a single source for patient, provider, and insurer – assuring that the treatment, level of care, and facility are appropriate for your needs. For example, Case Management can help with cases such as:

- Cancer
- Stroke
- AIDS
- Chronic illness
- Hemophilia
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Empire's Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by this plan is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact Empire's Medical Management Program at 1-800-982-8089.

Preventive Services

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal law. Many Preventive Care Services are covered by this Benefit Program with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. These services fall under four broad categories as shown below:

A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;

   Examples of these services are screenings for:

   Breast cancer;
   Cervical cancer;
   Colorectal cancer;
   High blood pressure;
   Type 2 diabetes mellitus
   Cholesterol;
   Child and adult obesity.

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations, including the well-child care immunizations as listed below:

   - DPT (diphtheria, pertussis and tetanus)
   - Polio
   - MMR (measles, mumps and rubella)
   - Varicella (chicken pox)
   - Hepatitis B Hemophilus
   - Tetanus-diphtheria
   - Pneumococcal
   - Meningococcal Tetramune
   - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives

C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") including:

   - Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.

   - Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry. Coverage shall be available as follows:

     For individuals who are:
     – Ages 52 through 65 - 1 baseline

- Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
- Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)

For individuals who meet the criteria of the above programs, including one or more of the following:
- Previously diagnosed with or having a family history of osteoporosis
- Symptoms or conditions indicative of the presence or significant risk of osteoporosis
- Prescribed drug regimen posing a significant risk of osteoporosis
- Lifestyle factors to such a degree posing a significant risk of osteoporosis
- Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

- Well-woman care visits to a gynecologist/obstetrician

- Women with no prior or family history of breast cancer, get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one.

- Women's contraceptives, sterilization procedures, and counseling: This includes contraceptive devices such as diaphragms, and implants, as well as injectable contraceptives.

- Breastfeeding support, supplies, and counseling: Covered in full when received from an In-Network Provider. Benefits for breast pumps are limited to one pump per pregnancy

- Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

The preventive services referenced above shall be covered in full when received from In-Network Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered under this paragraph is available on our website at *www.empireblue.com*, or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

- Screening for Prostate Cancer We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

  This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Details

In this section, we'll cover the details you need to know to make the plan work for you. Use it as a reference to understand:

- How to file a claim and get your benefits paid
- Your rights to appeal a claim payment or Medical Management decision
- What we mean by certain healthcare terms

Knowing the details can make a difference in how satisfied you are with your plan, and how easy it is for you to use. If you have additional questions, please visit *www.empireblue.com* or call Member Services at 1-844-243-5566.

Claims

IF YOU NEED TO FILE A CLAIM

Empire's EPO makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim, as the provider files the claim directly with Empire or the local Blue Cross/Blue Shield plan. However, you will have to file a claim for reimbursement for covered services if you have a medical emergency and obtain emergency services from a non- participating provider. To obtain a claim form, call customer service.

Send completed forms to:

Hospital Claims:

Empire BlueCross BlueShield
P.O. Box 1407 Church
Street Station
New York, NY 10008-1407
Attention: Institutional Claims Department

Medical Claims:

Empire BlueCross BlueShield
P.O. Box 1407 Church
Street Station
New York, NY 10008-1407
Attention: Medical Claims Department

Want more claim information? Now you can check the status of a claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting *www.empireblue.com*.

Fraud and Abusive Billing

We have processes to review claims before and after payment to detect fraud and abusive billing. In addition, We may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected for review under this program, then as part of the review process We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Assignment

You authorize Empire, on behalf of the Employer, to make payments directly to participating In-Network Providers for Covered Services. Empire also reserves the right to make payments directly to you. Except where Empire expressly indicates otherwise, in the case of services provided by an out of network provider, payments will always be made directly to you for services provided by the out of network provider. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Empire will discharge the Employer's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any applicable state or Federal law.

Once a Provider performs a Covered Service, Empire will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Tips for Filing a Claim

- File claims within 120 days from the date of service.
- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-844-243-5566 to have one mailed to you.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

IF YOU HAVE MEDICAL COVERAGE UNDER TWO PLANS (COORDINATION OF BENEFITS – COB)

Empire has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one health plan. The benefits provided by Empire will be coordinated with any benefits you are eligible to receive under the other plan.

Together, the plans will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Which Plan Pays Benefits First?

Here is how Empire determines which plan has primary responsibility for paying benefits:

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
  - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's healthcare expenses), the plan covering the parent with custody is primary.
  - If the parent with custody is remarried, his or her plan pays first, the step-parent's plan pays second and the non-custodial parent's plan pays third.
  - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's healthcare expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.
- If none of these rules apply, the plan that has covered the patient longest is primary.

If Empire Is the Secondary Plan

If the Empire plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.
- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

If You Receive An Overpayment Of Benefits

If you receive benefits that either should not have been paid, or are more than should have been paid, you must return any overpayment to Empire within 60 days of receiving it. Overpayments include:

- Payment for a service not covered by the plan
- Payment for a person not covered by the plan
- Payment that exceeds the amount due under your plan
- Duplicate payments for the same services

Health Care Fraud

Illegal activity adds to everyone's cost for healthcare. That's why Empire welcomes your help in fighting fraud. If you know of any person receiving Empire benefits that they are not entitled to, call us. We will keep your identity confidential. Want to see some recent examples of Empire's fraud prevention efforts? Visit *www.empireblue.com.*

REMEMBER	FRAUD HOTLINE 1-800-I.C.FRAUD (423-7283) During normal business hours

If You Have Questions About a Benefit Payment

Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the claim other than your co-payment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or an Explanation of Benefits (EOB) citing the reasons your claim was reduced or denied.

The notification will give you:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary
- An explanation of claims review procedures

If you have any questions about your claim, your Benefits Administrator may be able to help you answer them. You may also contact Empire Member Services at 1-844-243-5566 or in writing for more information. When you call, be sure to have your Empire I.D. card number handy, along with any information about your claim. Send written inquiries to:

Empire BlueCross BlueShield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Reimbursement For Covered Services

Maximum Allowed Amount

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers, is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the Blue Cross and Blue Shield Association BlueCard Program section for additional information regarding services received outside of Empire's service area.

The Maximum Allowed Amount is the maximum amount of reimbursement Empire will pay for services and supplies:

- that meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible, or have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under your Plan are not covered except for Emergency Care, or when allowed as an Authorized Service by Us. When you receive Covered Services from an Out-of-Network Provider, in an emergency or when authorized, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means We have determined that the claim submitted was inconsistent with procedure coding rules and/or our reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Empire to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit *www.empireblue.com*.

Providers who have not signed any contract with Us and are not in any of our networks are Out-of-Network Providers. If you use an Out-of-Network Provider for care other than Emergency Care or approved by Us as an Authorized Service, your claim will be denied

For Covered Services that you receive from an Out-of-Network Provider for Emergency Care, or for services approved as an Authorized Service, the Maximum Allowed Amount will be based on our Out-of-Network Provider fee schedule/rate or the Out-of-Network Provider's charge, *whichever is less*. Our Out-of-Network Provider fee schedule/rate may be accessed by calling the Customer Service number on the back of your identification card. The Maximum Allowed Amount on our Out-of-Network Provider fee schedule/rate has been developed by reference to one or more of several sources, including the following:

1. Amounts based on our In-Network Provider fee schedule/rate;
2. Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
3. Amounts based on charge, cost reimbursement or utilization data;
4. Amounts based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable Providers' fees and costs to deliver care; or
5. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.

Providers who are not contracted for this Plan, but contracted for other Plans with Us, are also considered Out-of-Network. The Maximum Allowed Amount reimbursement for services from these Providers will be based on Our Out-of-Network Provider fee schedule/rate as described above unless the contract between Us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Customer Service for help in finding In-Network Providers or visit our website at *www.empireblue.com*.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for an Authorized Service from an Out-of-Network Provider. In order for Us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

MEMBER COST SHARE

For certain Covered Services and depending on Your Plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment and/or Coinsurance).

If you go to an In Network Hospital or Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In Network Hospital or Facility, you will pay the In Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

AUTHORIZED SERVICES

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In Network cost share amounts (Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact Us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Care services from an Out-of-Network Provider and are not able to contact Us until after the Covered Service is rendered. If we authorize a Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Complaints, Appeals and Grievances

UTILIZATION REVIEW INTERNAL APPEALS

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
    - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

FIRST LEVEL APPEAL

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2)

business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external review.

Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Substance Use Appeal. If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external review within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external review is pending.

SECOND LEVEL APPEAL

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external review. **The four (4) month timeframe for filing an external review begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file for external review.**

A second level Appeal must be filed within 60 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

GRIEVANCES

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

A. Filing a Grievance. You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

B. Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

C. Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two 2 business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

COMPLAINTS

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. We will resolve complaints within the following time frames:

1. **Standard complaints.** Within 30 days of receiving all necessary information.
2. **Expedited complaints.** Within 72 hours of receiving all necessary information.

HOW TO REQUEST A COMPLAINT, APPEAL OR GRIEVANCE

To submit an appeal, call Member Services at the telephone number located on the back of your identification card, or write to the applicable address(es) listed below. Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

Empire Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

Ending Coverage

Certificates OF Creditable Coverage After Termination

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of coverage must be issued to a Member and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable Coverage will include the names of any Members terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group and/or when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members within a reasonable amount of time after Empire has terminated membership. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

Your ERISA Rights

Empire feels it is important for every member to know his/her rights, so please review the following information.

THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections under ERISA. Under ERISA you are entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor or Internal Revenue Service.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each covered member with a copy of this summary annual report.

Duties of the Plan Fiduciaries

In addition to creating certain rights for covered members, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called plan "fiduciaries," have a duty to do so prudently and in the interest of you and other covered members. Your employment cannot be terminated, nor can you be discriminated against in any way, to prevent you from obtaining your benefits or exercising your rights under ERISA.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a covered member of the plan.

- Under ERISA, you have the right to have your Plan Administrator review and reconsider your claim. If we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal our decision. You, or your authorized representative, may submit a written request for review. You have the right to obtain copies of documents relating to the decision without charge. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a state or federal court. A lawsuit for benefits denied under this coverage can be filed no earlier than 60 days after the claim was filed, and no later than two years from the date that the services were received. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If you submit a written request for copies of any plan documents or other plan information to which you are entitled under ERISA and you do not receive them within 30 days, you may bring a civil action in a federal court. The court may require the Plan Administrator to pay up to $110 for each day's delay until you receive the materials. This provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.
- In the unlikely event that the plan fiduciaries misuse the plan'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 a federal court. 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. But if you lose, because, for example, the case is considered frivolous, you may have to pay all costs and fees.

If you have any questions about your plan, contact your Plan Administrator or Member Services at 1-844-243-5566.

If you have any questions about your rights under ERISA, contact the regional office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor.

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
Director, New York Regional Office
33 Whitehall Street
New York, NY 10004
Telephone: 1-212-607-8600
Fax: 1-212-607-8681
Toll-Free: 1-866-444-3272

ACCESS TO INFORMATION

In addition to calling Member Services for claim and benefit information, you can contact them for:

- The names, business addresses and official positions of Empire's Board of Directors, officers, controlling persons, owners and partners
- Empire's most recently published annual financial statement
- A consumer report of grievances filed with the Insurance Superintendent
- Procedures that protect confidentiality of medical records and information
- A copy of Empire's Drug Formulary
- A directory of participating providers
- A description of our quality assurance program
- A notice of specific individual provider affiliations with participating hospitals
- Upon written request, specific written clinical criteria for determining if a procedure or test is medically necessary

For Members Who Don't Speak English

Empire will help members who speak languages other than English ask questions and file grievances in their first language. When you call Member Services, the operator will link you to an interpreter in your preferred language, who can facilitate the discussion. 24/7 NurseLine is also equipped to provide assistance in most languages.

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.
- The member has the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person acting on the member's behalf.

You have the responsibility to:

- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor’s office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let your Steamfitters Industry fund office know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

HIPAA Notice of Privacy Practices

Effective July 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information
We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents).
PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights
Under federal law, you have the right to:
- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information
We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws
HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints
If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information
Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes
You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information
We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

2016 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2016. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. References to "360° Health® Empire's Health Services Programs" are changed to "Health and Wellness Solutions".

B. The following is added to the Assignment of Benefits provision:

Any purported assignment of benefits shall be void. Any purported assignee of benefits shall acquire no rights by reason of any such purported assignment.

C. The following revisions apply to your Ambulatory Surgery benefit:

a. References to Ambulatory Surgery are hereby deleted and replaced with the following term:

Same Day surgery. Same-day or outpatient surgery is surgery performed in a hospital or other facility that does not require an overnight stay. For same-day surgery, the definition of "hospital" may include a free-standing ambulatory surgical facility that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan. "Facility" does not include a provider's office.

b. i. The following provision is deleted from your Benefit Booklet:

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or medically necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

ii. The following provision is added to your Benefit Booklet:

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a hospital outpatient facility
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or medically necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

D. The Applied Behavior Analysis Benefit Maximum is hereby deleted and replaced as follows. The maximum benefit for Medically Necessary Applied Behavioral Analysis under your Plan is hereby amended to unlimited visits per member per year.

E. The following defined terms are added to your Benefit Booklet:

a. Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical

therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this benefit plan.

b. Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this benefit plan that is licensed, registered, certified or accredited as required by law.

2017 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2017. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. The following is added to the Introduction section of your Benefit Booklet:

Your Employer has agreed to be subject to the terms and conditions of Empire's provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

B. The BlueCard and/or Inter-Plan Program provision language is hereby deleted and replaced with the following:

Inter-Plan Programs.

1. **Out-of-Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area We serve, (the "Empire Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

   When You receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

2. **BlueCard® Program.** Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

   When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:
   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to Us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

   Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. **Special Cases: Value-Based Programs.** BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments. Additional information is available upon request.

4. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed onto You.

5. **Non-Participating Providers Outside Our Service Area.**

   a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Service Area by Non-Participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

   b. **Exceptions.** In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

6. **BlueCard Worldwide® Program.** If You plan to travel outside the United States, call Member Services to find out Your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with You.

   When You are traveling abroad and need medical care, You can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

   If You need inpatient hospital care, You or someone on Your behalf, should contact Us for preauthorization. Keep in mind, if You need emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

   How claims are paid with BlueCard Worldwide. In most cases, when You arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:
   - Doctors services;
   - Inpatient hospital care not arranged through BlueCard Worldwide; and
   - Outpatient services.

   You will need to file a claim form for any payments made up front.

   When You need BlueCard Worldwide claim forms, You can get international claim forms in the following ways:
   - Call the BlueCard Worldwide Service Center at the numbers above; or
   - Online at *www.bluecardworldwide.com*.

   You will find the address for mailing the claim on the form.

C. The Subrogation and Reimbursement provisions are hereby deleted and replaced with the following:

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

1. Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

2. Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to your negligence.

You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan’s equitable lien applies is a Plan asset.

Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
You fail to cooperate.

In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

3. Your Duties

You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.

You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

You must not do anything to prejudice the Plan's rights.

You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

D. Provision language related to Special Enrollment Periods is hereby deleted and replaced with the following:

You, Your Spouse or Child, can also enroll for coverage within 60 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice within 60 days of the loss of coverage. The effective date of Your coverage will be the date indicated on the application.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice within 60 days of one of these events.. The effective date of Your coverage will be the date indicated on the application.

E. The following is added to the Exclusions and Limitations section of Your Benefit Booklet.

- **Conversion Therapy.** We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

2018 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2018. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

F. The following is added to the listing of services requiring prior authorization or precertification:

- Genetic Testing

G. The BlueCard and/or Inter-Plan Program provision language is hereby deleted and replaced with the following:

Inter-Plan Programs

7. Out-of-Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside of the geographic area We serve (the "Empire Service Area"), the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and**]** most dental or vision benefits.

8. BlueCard® Program. Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not

affect the price We used for Your claim because they will not be applied after a claim has already been paid.

9. **Special Cases: Value-Based Programs.** BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments.

10. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

11. **Non-Participating Providers Outside Our Service Area.**

    a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Service Area by non-participating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

    b. **Exceptions.** In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

12. **Blue Cross Blue Shield Global Core® Program.** If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United State may be different from services received in the United States. The plan only covers Emergency, including ambulance and Urgent Care outside of the United States. Remember to take an up to date health ID card with You.

    When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

    How claims are paid with Blue Cross Blue Shield Global Core®. In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:

    - Doctors services;
    - Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
    - Outpatient services.

    You will need to file a claim form for any payments made up front.

    When You need Blue Cross Blue Shield Global Core® claim forms, You can get international claim forms in the following ways:

    - Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
    - Online at*www.bcbsglobalcore.com*.

    You will find the address for mailing the claim on the form.

H. The "Initial Decisions" section of the "Health Management" chapter of your benefit booklet is hereby deleted and replaced with the following:

1. Preauthorization Reviews.

d. Non-Urgent Preauthorization Reviews. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of the request.

If We need additional information, We will request it within fifteen (15) calendar days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period allowed to submit the additional information.

e. Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

f. Court Ordered Treatment. With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

2. Concurrent Reviews

4. Non-Urgent Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

If We need additional information, We will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45- day period allowed to provide the additional information.

5. Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider within 24 hours of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your

designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

6. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

3. **Retrospective Reviews.** If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

   Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

4. **Retrospective Review of Preauthorized Services.** We may only reverse a preauthorized treatment, service or procedure on retrospective review when:
   - The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
   - The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
   - We were not aware of the existence of such information at the time of the Preauthorization review; and
   - Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

I. Coverage for Online Visits is revised as follows:

- **Online visits.** Your coverage includes online physician office visits. Covered Services include a visit with the physician using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed Primary Care Physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

  Member Access. To begin the online visit, log on to *www.livehealthonline.com* and establish an online account by providing some basic information about You and Your insurance plan. Before You connect to a Doctor, You will be asked to identify: the kind of condition You want to discuss with the Doctor, list Your local pharmacy, provide information for the credit card You want Your cost share for the visit to be billed to, agree to the terms of use, and select an available Physician. If You are not in New York State when You seek an online visit, You will need to check to be sure an online Doctor is available in the state You are in because online Doctors are not available in every state.

  The visit with the Physician will not start until You provide the above information and click "connect." The visit will be documented in an electronic health record. You may access Your records and print them, and may email or fax them to Your Primary Care Physician.

  Note about Covered Services. Online visits are not meant for the following purposes:
  - To get reports of normal lab or other test results;
  - To request an office appointment;

- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist Doctor;
- To request Preauthorization for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

J. The following provisions related to Claim Determinations are added to your benefit booklet:

1. **Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Booklet for information on how We coordinate benefit payments when You also have health coverage with another plan.

2. **Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at *www.empireblue.com*. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Booklet or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Booklet; on Your ID card or visiting Our website at *www.empireblue.com*.

3. **Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 18 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 18 month period, You must submit it as soon as reasonably possible.

4. **Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

5. **Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

   For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Booklet.

6. **Pre-Service Claim Determinations.**

   1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

      If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee), within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours of receipt of the request. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) within 48 hours of the earlier of Our receipt of the additional information or, if information was not received, at the end of the 48-hour period allowed to submit the information.

7. **Post-Service Claim Determinations.** A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

K. The definition of "Providers" is revised as follows:

- For behavioral healthcare purposes, "provider" includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.

Definitions

Refer to these definitions to help you better understand your coverage. Need more help? Additional terms and definitions can be viewed at *www.empireblue.com.*

Adverse Determination

A communication from Empire's Medical Management that reduces or denies benefits.

Ambulatory Surgery

See "same-day surgery."

Annual Out-of-Pocket Limit

The most you pay during a Benefit Period in cost sharing before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Annual Out-of-Pocket Limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Annual Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Your Benefits At A Glance" section for cost shares that apply to Your Plan.

Applied Behavior Analysis (ABA)

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorized Services

See "pre-certified services."

Autism Spectrum Disorder (ASD)

Any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including Autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).

BlueCard® Program

Emergency Care through the BlueCard® Program*

Empire also participates in a program administered by the Blue Cross and Blue Shield Association called the BlueCard Program. This program is separate from the BlueCard PPO program, described below and is available to you only if you need emergency care. BlueCard network providers, as opposed to BlueCard PPO providers, are considered out-of-network providers, except for emergency services. The BlueCard Program helps reduce your costs when you obtain emergency care outside of the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan ("local Blue Plan"). Just show your Empire ID card to a participating provider and comply with the other terms in your Contract or Certificate of Coverage when receiving these services. When you obtain health care through the BlueCard Program, the portion of your claim that you are responsible for ("member liability") is, in most instances, based on the lower of the following:

- the billed amount that the participating provider actually charges for covered services, or
- the negotiated price that the local Blue Plan passes on to Empire.

Here's an example of a negotiated price and how it benefits you:

A provider's standard charge is $100, but he/she has a negotiated price of $80 with the local Blue Plan. If your coinsurance is 20%, pay $16 (20% of $80) instead of $20 (20% of $100).

The negotiated price may reflect:

- A simple discount from the provider's usual charges, which is the amount that would be reimbursed by the local Blue Plan;
- An estimated price that has been adjusted to reflect expected settlements, withholds, any other contingent payment arrangements and any non-claim transactions with the provider; or
- The provider's billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

Plans using the estimated price or average savings methods may adjust their prices in the future to ensure appropriate pricing. However, the amount you pay is considered the final price. A small number of states have laws that require that your member liability be calculated based on a method that does not reflect all savings realized, or expected to be realized, by the local Blue Plan on your claim, or that requires that a surcharge be added to your member liability. If you receive covered health care services in any of these states, member liability will be calculated using the state's statutory methods that are in effect at the time you receive care. If you have any questions about the BlueCard Program, contact Empire Member Services.

Note: Some services require precertification from Empire's Medical Management Program before you receive care.

∗***For emergency room visits for emergency care, or emergency inpatient stays required by your medical condition, you can use any hospital provider and receive in-network benefits.***

BlueCard® PPO Program

Care When you are Out of Our Service Area Within the U.S.

If you are traveling outside the Empire service area, the BlueCard® PPO program lets you use other Blue Cross and/or Blue Shield plans' PPO networks of physicians, hospitals and other health care providers. As an EPO member, you are automatically enrolled in the BlueCard® PPO program. This allows you to receive in-network benefits across the country outside of our network area from providers participating with other Blue Plans' PPO networks. As long as these services are covered services under your Contract or Certificate, they will be treated as in-network services. If you are traveling and need medical care, call 1-800-810-BLUE (2583), for the names and addresses of the PPO providers nearest you. You may also visit the Blue Cross and Blue Shield Association Web site to locate providers in other states at www.bcbs.com.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides hospital and professional coverage through an international network of healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance.
Here's how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®[1] Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the maximum allowed amount.

Co-payment

The fee you pay for office visits and certain covered services when you use in-network providers. The plan then pays 100% of remaining covered expenses.

Covered Services

The services for which Empire provides benefits under the terms of your contract. For example, Empire covers one in-network annual physical exam.

Hospital/Facility

For purposes of certifying inpatient services, a hospital or facility must be a fully licensed acute-care general facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care
- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan.

For physical therapy purposes, the definition of a "hospital" may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan other than specified above.

For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.

For behavioral healthcare purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

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

Empire's EPO does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps

In-Network Benefits

Benefits for covered services delivered by in-network providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is in Empire's PPO network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Itemized Bill

A bill from a provider, hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider's name and address and descriptions of each service, while a hospital bill will have the subscriber's name and address, the patient's date of birth and the plan holder's Empire identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.

Lifetime Maximum

The maximum amount of benefits your plan will pay for covered expenses over the course of your lifetime.

Maximum Allowed Amount (MAA)

The maximum dollar amount of reimbursement for Covered Services. Please see the Maximum Allowed Amount Reimbursement for Covered Services section for additional information.

Medical Necessity

We Cover benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it. We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;

- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service of sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or infusion of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in the physician's office of the home setting.

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's PPO contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

Operating Area

Empire operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A hospital or facility that:

- Is in Empire's PPO network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Plan Administrator

The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. Empire is not the Plan Administrator. To identify your Plan Administrator, contact your employer or health plan sponsor.

Pre-certified Services

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by your plan. Failure to pre-certify may result in a reduction or denial of benefits.

Provider

A hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for covered services within the scope of the practitioner's license.

For behavioral healthcare purposes, "provider" includes care from psychiatrists, psychologists or certified social workers (with three or more years of post-degree supervised experience), providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital.

Treatment Maximums

Maximum number of treatments or visits for certain conditions.

AudioHealth Library Topics

Following is a list of some of our most popular health-related audiotape topics that you can listen to free of charge, 24 hours a day, seven days a week, when you call 24/7 NurseLine at 1-877-TALK-2RN (825-5276). See the 360˚ Health section for more information on the 24/7 NurseLine and instructions on how to listen to the tapes. These are our most requested audiotapes. If you do not see the topic that interests you, just ask one of the NurseLine nurses.

Abdominal Problems

1600 Appendicitis
1451 Constipation
1618 Crohn's Disease
1260 Dehydration
1452 Diarrhea
1605 Diverticulosis and Diverticulitis
1402 Food Poisoning
1608 Gallbladder Disease
2154 Gallbladder Surgery
1612 Gastroesophageal Reflux Disease
1610 Heartburn
1952 Hepatitis
1403 Hernia
1603 Inflammatory Bowel Disease
1611 Irritable Bowel Syndrome
2576 Kidney Stones
1462 Nausea and Vomiting
1609 Rectal Problems
1613 Ulcers
2257 Urinary Incontinence in Women
1291 Urinary Tract Infections

Allergies

1000 Allergies
2770 Drug Allergies
1002 Food Allergies
1007 What About Allergy Shots?

Back and Neck Pain

1450 Low Back Pain
1463 Herniated Disk
2174 Low Back Problems , Surgery for
1457 Neck Pain

Bone, Muscle and Joint Problems

1030 Arthritis
1780 Bunions
2103 Bursitis and Tendon Injury
1781 Calluses and Corns
2104 Carpal Tunnel Syndrome
1038 Fibromyalgia
1039 Gout
1784 Heel Spurs
1031 Juvenile Rheumatoid Arthritis
1033 Lupus
2106 Muscle Cramps and Leg Pain
2259 Osteoarthritis
1032 Osteoporosis
1034 Rheumatoid Arthritis
2169 Rotator Cuff
1456 Sports Injuries
2105 Strains, Sprains, Fractures and Dislocations
2151 Surgery for Carpal Tunnel Syndrome
1461 TM Disorder

Cancer

1105 Cancer Pain
1110 Colon Polyps
1113 Colorectal Cancer
1120 Women's Cancer
1124 Lung Cancer

Chest, Respiratory and Circulatory Problems

1981 Asthma in Teens and Adults
1908 Atrial Fibrillation (irregular heartbeats)
1983 Bronchitis
1915 Cardiac Rehabilitation
1903 Causes of Heart Attack
1900 Chest Pain
1976 Chronic Obstructive Pulmonary Disease (COPD)
1400 Colds
1907 Heart Failure
1980 Emphysema
1455 Fever
1904 Heart Attack Prevention
1401 Influenza (Flu)
1648 Laryngitis
1910 Mitral Valve Prolapse
1911 Pacemakers
1986 Pneumonia
1406 Sinusitis
1459 Sore Throat and Strep Throat
1081 Stroke Rehabilitation
1460 Swollen Lymph Nodes
1912 Varicose Veins
1407 Viral and Bacterial Infection

Chronic Conditions

1060 ALS (Lou Gehrig's Disease)
1061 Alzheimer's Disease
1950 Chronic Fatigue Syndrome
2570 Chronic Kidney Disease
1063 Epilepsy
1953 Hepatitis B
1909 High Blood Pressure
1832 High Cholesterol
2623 Iron Deficiency Anemia
1959 Living with HIV Infection
1065 Multiple Sclerosis
1066 Parkinson's Disease
1512 Prediabetes
2550 Thyroid Problems
1508 Type 1 Diabetes
1500 Type 2 Diabetes
1501 Type 2 Diabetes: Living with Complications
1502 Type 2 Diabetes: Living with the Disease
1503 Type 2 Diabetes: Recently Diagnosed

Ear, Nose and Throat

1516 Diabetic Retinopathy
1453 Dizziness and Vertigo
1264 Ear Infections
1640 Earwax
1646 Hearing Loss 1641
Inner Ear Infection (Labrynthitis) 1644
Meniere's Disease
1643 Swimmer's Ear
1650 Tonsillitis

Eye Problems

1700 Eye Problems
2152 Cataract Surgery
1709 Cataracts
1710 Color Blindness
1703 Contact Lens Care
1708 Eye Infections
1705 Eye Injuries
1717 Floaters and Flashes
1712 Glaucoma
1711 Macular Degeneration
1716 Laser Surgery for Nearsightedness
1713 Strabismus
1707 Styes
1702 Vision Tests

First Aid and Emergencies

1750 Animal and Human Bites
1761 Burns
1255 Choking
1762 Cuts
2337 Frostbite
1901 Heart Attack
1759 Heat Exhaustion and Heat Stroke
2256 Hypothermia
2203 Importance of CPR Instructions
1751 Insect and Spider Bites and Stings
1458 Nosebleeds
1763 Poisoning
1764 Puncture Wounds
1766 Removing Splinters
1752 Snake Bites
1067 Stroke
1754 Tick Bites

Headaches and Nervous System Problems

1062 Bell's Palsy
1515 Diabetic Neuropathy
1068 Guillain-Barre Syndrome
1064 Encephalitis
1405 Migraine Headaches
1404 Tension Headaches

Home Health Medicines and Supplies

2000 Bulking Agents and Laxatives
2007 Cold and Allergy Remedies
2003 Cough Preparations
2002 Decongestants
1270 How to Take a Temperature
2001 Pain Relievers
1758 Self-Care Supplies

Infant and Child Health

1250 ADHD
1251 Bed-wetting
2753 Bottle-feeding
1254 Chickenpox
1278 Childhood Rashes
1256 Circumcision
1257 Colic
1258 Croup
1261 Diaper Rash

Infant and Child Health

1080 Dyslexia
2436 Fetal Alcohol Syndrome
1253 Fever, Age 3 and Younger
1267 Fifth Disease
1268 Growth and Development of the Newborn
1269 Hand-Foot-Mouth Disease
1837 Healthy Eating for Children
1272 Impetigo
1274 Measles
1275 Mumps
1280 Pinworms
1259 Reye's Syndrome
1283 Roseola
1284 Rubella (German Measles)
1287 Sudden Infant Death Syndrome (SIDS)
1288 Teething
1247 Temper Tantrums
1292 Thrush
1289 Thumb-Sucking
1290 Toilet Training
1293 Urinary Tract Infections in Children

Infectious Diseases

1408 Avian Influenza (Bird Flu)
1951 Infectious Mononucleosis
1956 Tuberculosis
1965 West Nile Virus

Living Healthy

1279 Immunizations
1295 Health Screenings
1830 Living a Balanced Lifestyle
1831 Guidelines for Eating Well
1833 Be Physically Active
1834 Healthy Weight
1835 Mind-Body Connection
1838 Alcohol and Drug Problems
1841 Be Tobacco-Free
1846 Managing Stress
1853 Healthy Snacks
1964 Relaxation Skills
2204 Accident and Injury Prevention
2428 Treatment for Alcohol Use Problems
2435 Teen Alcohol and Drug Abuse

Medical Tests and Procedures

1506 Home Blood Sugar Monitoring
1532 Exercise Electrocardiography
1533 Complete Blood Count (CBC)
1534 Chest X-ray
1535 Chorionic Villus Sampling
1536 CT Scan of the Body 1537 Electroencephalogram
1538 Electrocardiogram
1539 Electromyography (EMG)
1540 Barium Enema
1541 Upper Gastrointestinal (GI) Series
1542 Magnetic Resonance Imaging
1546 Lung Function Tests

1547 Abdominal Ultrasound
2155 Cystoscopy
2156 Dilation and Curettage
2157 Episiotomy
2158 Surgery for Hemorrhoids
2159 Hernia Surgery
2160 Hip Replacement Surgery
2162 Arthroscopy
2163 Knee Replacement Surgery
2164 Laparoscopy
2165 Ear Tubes
2171 Tonsillectomy and Adenoidectomy
2503 Shared Decisions about Surgery

Men's Health

1128 Prostate Cancer
1545 Prostate-Specific Antigen Test (PSA Test)
2031 Hair Loss
2034 Benign Prostatic Hyperplasia (Enlarged Prostate)
2036 Testicular Problems
2167 TURP for BPH

Mental Health Problems and Mind-Body Wellness

1069 Bipolar Disorder
1070 Schizophrenia
1071 Dementia
1230 Domestic Violence
1240 Child Maltreatment
1845 Stress Management
2051 Obsessive-compulsive Disorder
2052 Eating Disorders
2055 Panic Attacks and Panic Disorder 2057 Depression
2059 Grief
2063 Social Anxiety Disorder
2066 Suicide

Partnership with your doctor

1201 Patients Bill of Rights
1202 Caregiver Secrets
1800 Skills for Making Wise Health Decisions
1801 Work in Partnership with your Doctor
1802 Finding a Doctor Who Will be a Partner

Senior Health

1836 Seniors Staying Active and Fit
2004 Medication Problems in Seniors
2006 Medications and Older Adults
2240 Hospice Care
2245 Care at the End of Life 2251 Nutrition for Older Adults 2261
Skin and Nail Problems in Seniors

Skin Problems

1129 Skin Cancer
1273 Lice and Scabies
1755 Blisters
1785 Ingrown Toenails
2330 Acne
2332 Boils
2333 Cold Sores
2334 Dandruff
2336 Atopic Dermatitis
2338 Hives
2343 Rashes
2344 Psoriasis
2346 Fungal Infections
2349 Shingles
2352 Sunburn
2353 Warts

Sleeping Disorders

2400 Sleep Problems
2403 Sleep Apnea
2406 Snoring

Women's Health

1107 Breast Health
1111 Ovarian Cancer
1112 Polycystic Ovary Syndrome
1211 Multiple Pregnancy: Twins or More
1504 Gestational Diabetes
1531 Breast Biopsy
1544 Pelvic Exam and Pap Test
1548 Ultrasound for Normal Pregnancy
2312 Pelvic Inflammatory Disease
2426 Pregnancy, Precautions During
2640 Bacterial Vaginosis
2643 Yeast Infections
2650 Menopause
2651 Hormone Therapy
2670 Missed or Irregular Periods
2672 Endometriosis
2673 Uterine Fibroids
2674 Hysterectomy
2675 Bleeding Between Periods
2677 Functional Ovarian Cysts
2678 Menstrual Cramps
2679 Dsyfuntional Uterine Bleeding
2680 Toxic Shock Syndrome
2700 How to Make a Healthy Baby
2701 Home Pregnancy Test
2704 Danger signs during pregnancy
2705 Normal Pregnancy
2706 Symptoms and Stages of Labor
2708 Diet During Pregnancy
2709 Exercise During Pregnancy
2710 Rubella and Pregnancy
2714 Amniocentesis
2717 Miscarriage
2719 Stretch Marks
2720 Cesarean Section
2723 Pelvic Organ Prolaps
2724 Premenstrual Syndrome

Women’s Health

2725 Pregnancy, Symptoms and Stages of
2750 Postpartum Depression
2751 Breast Feeding
2752 Complications after delivery
2754 Labor, Delivery, and Postpartum Period
2755 Mastitis While Breast-Feeding
2756 Rh Sensitization During Pregnancy
2757 Weaning

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic
ءارجإ ذاختا للإ جاتحت دق .قمهملا ديعاوملا عبتت للع ص رحا .كل قمدقملا ايازمللا وأ كلبط لوح قمهم تامولعم للع راعشإلا اذه يوتحي لاصتلاا ىجر ُي
ا ًزاجم كنغلب قدعاسملاو تامولعملا هذه للع لوصحلا لكل قحي .قفلكتلا قرادلإ وأ ايازمللاب ظافتحلال قددحم ديعاوم ليق.
قدعاسملل كب قصاخلا فيرعتلا ققاطب للع دوجوملا ءاضعلأا تامدخ مقرب)TTY/TDD:711(.

Bengali
আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিটিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। ববববববববববববববববববববববববববববববববববব
বববববববব সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish
Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)

Tagalog
May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu
وک نوتگلا اي نودئاف ےنپا ۔ےیھکید نیخیرات مہا ۔ےہ لمتشم رپ تامولعم مہا نیم ےراب ےک نودئاف اي تساوخرد یک پآ سٹون ہي روا تامولعم نا تفم نیم نابز
ںیہاچ وک پآ ۔ےہ یتکسوہ ترورض یک ےنرک مادقا رپ ںوخیرات ضعب وک پآ ےیل ےک ےنرک مظنم
۔نیرک لاک وک ربمن سورس ربمم دوجوم رپ ڈراک یڈ یئآ ےنپا ےیل ےک ددم ۔ےہ قح اک لوصح ےک ددم)TTY/TDD:711(

Yiddish
מעד ןיא סעטאד עגיטיונ ראפ טקוק .שזדירעוואק רעדא עיצאקעלפא רעייא ןגעוו עיצאמראפניא עגיטכיוו טאה גנודלעמ םעד
ןפלעה רעדא שזדירעוואק טנוזעג ערעייא ןטלאה וצ זניילדעד עסיוועג םדוק עיצקא ןעמענ ןפראד ךילגעמ טעוו ריא .גנודלעמ
רעבמעמ יד טפור .םניחב ךארפש רעייא ןיא טפליה ןוא עיצאמראפניא םעד ןעמוקאב וצ טכער יד טאה ריא .טסאקטימ
ףליה ראפ לטראק רעייא ףיוא רעמונ ןעגנונידאב)TTY/TDD:711(.

05179NYMENMUB 06/16 Notice

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.