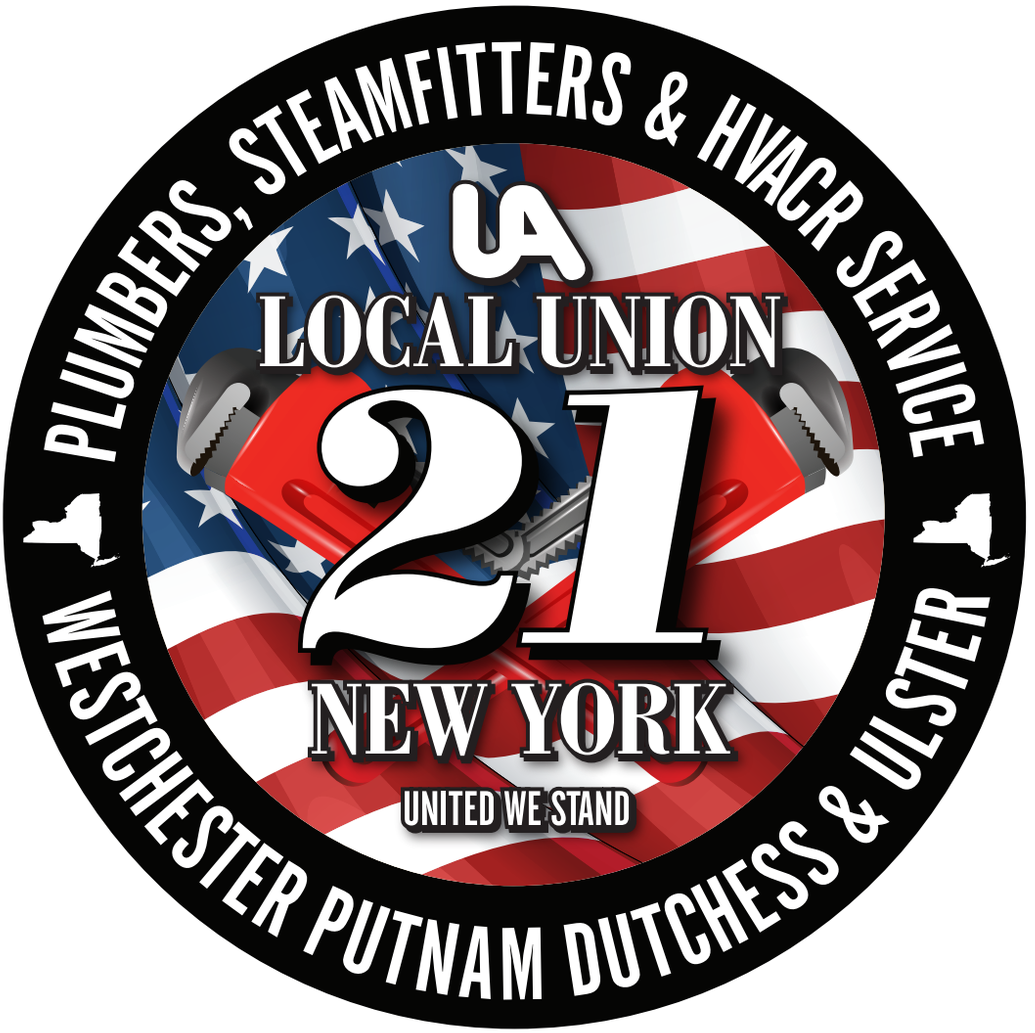
PLUMBERS AND STEAMFITTERS LOCAL 21

WELFARE FUND



Active Summary Plan Description (SPD)

Effective January 1, 2020

PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

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INTRODUCTION

This booklet describes the health and welfare coverage available to you under the Plumbers and Steamfitters Local 21 Welfare Fund (the **Fund/Plan**). The Plan described in this document is effective January 1, 2020 except for those provisions that specifically indicate other effective dates, and replaces all other Summary Plan Descriptions (SPD) previously provided to you by the Plan. This coverage includes:

- Life Insurance and AD&D Benefits
- Medical Benefits
- Prescription Drug Benefits
- Vision Benefits
- Employee Assistance Benefits
- Health Reimbursement Account (HRA)

Please read this information carefully – and share it with your family. Terms that are capitalized are defined in the *Definitions* section of this booklet.

This section of the booklet describes the above benefits as well as eligibility requirements and other important Plan information. It also contains a description of the medical benefits provided by the Plumbers and Steamfitters Local 21 Welfare Fund, as well as other benefits as listed above. Remember, not every expense incurred for health care is covered by the Plan.

The Board of Trustees of the Plumbers and Steamfitters Local 21 Welfare Fund is committed to maintaining health care coverage for Participants and their eligible dependents at an affordable cost. However, as future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverage at any time for any reason.

This document together with any insurance certificates constitute the Summary Plan Document (SPD) and Plan Document.

Provisions of this document contain important information. If you have questions about your coverage or your obligations under the terms of the Plan, please seek help or information. If the Plan is amended, you will be sent information explaining the changes. If these later notices describe a benefit or procedure different from what is described here or in any Certificate of coverage, you should rely on the later information. Keep this document with notices of Plan changes in a safe and convenient place for reference. However, keep in mind that you should rely on the information in this booklet or Certificates of coverage (or subsequent written changes) for definitive information.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

WHEN YOU HAVE QUESTIONS ABOUT YOUR BENEFITS

The following chart provides phone numbers you may call if you have questions about your benefits:

When you have questions about your benefits…		
For questions about…	**Contact:**	**At this phone number:**
Enrollment and Eligibility (Active/Retirees)	Fund Office	(914)-737-7220 (phone) (914) 737-7283 (fax)
Hospital and Medical	Empire BlueCross BlueShield	1-800-553-9603 (phone) TDD for hearing impaired: 1-800-682-8786 (phone)
Life Insurance and Accidental Death and Dismemberment	Mutual of Omaha	(800) 775-8805 (phone)
Prescription Drug Benefits	OptumRx	(866) 863-1408 (phone)
Employee Assistance Program Benefits	Lower Hudson Valley – EAP	(914) 245-6300 or 1-800-EAP-2799 outside the (914) area code or contact the Fund Office
Vision Benefits	Fund Office	(914) 737-7220 (phone) (914) 737-7283 (fax)
Health Reimbursement Account (HRA)	Fund Office	(914) 737-7220 (phone) (914) 737-7283 (fax)

Participants are eligible for the benefits outlined above and described in this section of the booklet upon meeting the Plan's eligibility rules. If there is any difference between the information contained in this summary and the contracts with insurers, the contracts will govern.

SPANISH LANGUAGE ASSISTANCE:

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Beneficios Administracion en ***(914) 737-7220.***

If you have any questions about your benefits under the Plumbers and Steamfitters Local 21 Welfare Fund, please call the Fund Office at (914) 737-7220.

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IMPORTANT INFORMATION YOU AND/OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN

In addition to information you must furnish in support of any claim for Plan Benefits under this Plan, you and/or your covered Dependents must immediately furnish any information you and/or your Dependents may have that may either affect eligibility for coverage under the Plan or the Fund Office's or its insurers'/claims administrators' ability to properly administer the benefits. These events include, but are not limited to:

- Name change.
- Address change. (Advise the Fund Office promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage.)
- Marriage, divorce, legal separation or death of you or any covered Spouse or Dependent Child.
- Birth, adoption or placement for adoption (including a proposed adoption) of a Dependent Child.

You will also need to furnish the information below regarding your Dependents that may affect their eligibility for coverage under the Fund. This information must be provided to the Fund Office as well as to the Fund's insurer(s) or claims administrator(s). The required information includes but is not limited to:

- A Dependent's Medicare enrollment or disenrollment, Social Security Disability Benefits Award or Termination.
- The existence of other medical, prescription drug or dental coverage.
- Any information regarding the status of your Dependent Child, including, but not limited to your Dependent Child reaching the Plan's limiting age, age 26. *Note, however, under certain circumstances coverage for a disabled child 26 years of age or older who has a physical or mental Handicap and is incapable of self-support may be continued beyond the Plan's limiting age. See the Eligibility section of this booklet for additional information about coverage for disabled Dependent Children.*

ELIGIBILITY PROVISIONS

Initial Eligibility for Active Employees

All Journeymen, Steamfitters, Plumbers and Apprentices of Participating Employers who meet the hours worked requirements, as described below, are eligible for coverage. In addition, all active salaried employees of the Plumbers and Steamfitters Local Union No. 21, the Plumbers and Steamfitters Local Union No. 21 Pension Fund and the Plumbers and Steamfitters Local Union No. 21 Welfare Fund are eligible for coverage.

In addition, if you are enrolled in an approved program at the Plumbers and Steamfitters Local Union No. 21 Education and Training facility, 245 hours will be credited for eligibility purposes, provided you were working in covered Employment immediately prior to enrolling in the training program.

When you Become Eligible

You will be covered for benefits from the first day of the calendar quarter following the Work Period in which you accumulate the required number of hours, as follows:

- Five hundred (500) hours for one or more Participating Employer(s) during a designated 6-month Work Period; or
- One Thousand (1,000) hours for one or more Participating Employer(s) during a designated 12-month Work Period.

Designated Work Period		Benefit Quarter
If you work 500 hours during the following 6 month Work Period:	**If you work 1000 hours during the following 12 month Work Period:**	**You will be eligible for benefits for the Benefit Quarter running from:**
June 1st to November 30th	December 1st to November 30th	January 1st to March 31st
September 1st to February 28th	March 1st to February 28th	April 1st to June 30th
December 1st to May 31st	June 1st to May 31st	July 1st to September 30th
March 1st to August 31st	September 1st to August 31st	October 1st to December 31st

Each Work Period is reviewed as of the last month to see if you meet the eligibility rules. If you meet the eligibility requirement, the Fund Office will notify you and automatically enroll you for benefits in accordance with the Eligibility provisions of the Plan. Once you meet the hours requirements and properly enroll for coverage, you will be covered for benefits and considered a "Participant" in the Plan.

When you become eligible for benefits, your Dependents also become eligible for benefits. However, your Dependents will not be covered until you complete the enrollment form

and submit it to the Fund Office together with any applicable proof of Dependent Status in accordance with the Enrollment provisions of the Plan.

In addition to the above, your work history will be reviewed each Work Period to determine if you are working in covered Employment or if not working, you are ready, willing and able to work on the date the benefits are to begin. If, at the beginning of the Benefit Quarter when benefits are to begin, you are not working in covered Employment or are not ready, willing and able to work (e.g., you refuse work from a Contributing Employer), your coverage effective date will be delayed until you return to covered Employment or are again ready, willing and able to work. This provision does not apply if you are not working in covered Employment for reasons related to health factors (e.g., due to illness or injury). If you are absent for work on the day that benefits are to begin for reasons related to health factors (e.g., due to illness or injury), coverage will begin when you are eligible (the first day of the Benefit Quarter), as described in the table above. The Fund Office will determine if you are working in covered Employment or ready, willing and able to work based on a process prescribed by the Trustees.

Please note, however, that if you retire and are collecting a pension under either of the Plumbers & Steamfitters Local 21 Pension Funds, you will not be subject to the above ready, willing and able to work provisions and your active coverage will continue until all eligibility accrued based on hours worked has been exhausted.

Maintaining coverage after Enrollment

Once you have met initial eligibility requirements, your work history is reviewed as of the end of each subsequent Work Period to see if you continue to meet the eligibility rules. If you work the required number of hours during a Work Period, your coverage will automatically continue for the following Benefit Quarter, uninterrupted. If you fail to work the required number of hours, your coverage will cease and you will have to meet the initial eligibility requirements again in order to regain coverage. At that time, you will be offered COBRA Continuation of Coverage. Alternatively, you may consider purchasing Marketplace coverage in order to avoid a gap in health insurance coverage. See the *COBRA Continuation of Coverage* section of this booklet for more details.

Example: **A new participant works 500 hours during the time period June 1st – November 30th. S/he will become eligible for Welfare Fund coverage effective January 1st and coverage will last until March 31st. To continue eligibility for the next three months, the participant must work at least 500 hours in covered Employment during the Work Period September 1st – February 28th or 1000 hours during the period March 1st of the prior year to February 28th.**

Note: If the participant in the above example is not working in covered Employment or is not ready, willing and able to work on January 1st (for reasons other than illness or injury), his or her benefits will not begin until such time as he returns to covered Employment or is ready, willing and able to work in covered Employment.

If, after you've met the initial eligibility requirements, you do not meet the work hours required to maintain eligibility, you will be able to self-pay a maximum of 50 hours to achieve the 500 or 1,000 hours required to maintain eligibility if either you've worked 450 hours or more but less than 500 hours or you've worked 950

hours or more but less than 1,000 hours. You may **not** self-pay to gain Initial Eligibility for coverage; or, if you have fewer than 450 hours; or, in lieu of paying COBRA premiums. If you have questions about self-pay, contact the Fund Office. Once you are no longer eligible for coverage, you will be offered COBRA Continuation of Coverage.

Reinstatement of Eligibility

If your eligibility terminates under the Plan, your coverage will be reinstated once you meet the Initial Eligibility rules outlined in the *Eligibility* section.

Your Eligible Dependents

Your Eligible Dependents are eligible for benefits under this Plan. For purposes of this Plan, your eligible Dependent(s) include:

- Your lawful spouse; and
- Your Children (married or unmarried) until the end of the month they reach the age of 26. "Child" includes a natural child, stepchild and adopted child including a proposed adopted child during any waiting period prior to the finalization of the child's adoption. 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.

A Dependent Child whose coverage under this Plan would otherwise terminate solely due to attainment of age 26 shall continue to be considered a Dependent if:

- The Child is unmarried;
- The Child is total and permanently disabled. For purposes of this section, **Disability or total and permanent Disability** means the inability of a covered Dependent to perform the normal activities or duties (including occupational) of a person of the same age and gender and the Dependent is incapable of self-sustaining employment (substantial gainful employment) as a result of the Disability;
- The Child became so Disabled before attaining the age of 26;
- The Child is chiefly dependent on you for support and maintenance and is claimed on your tax return as a dependent; and
- Written evidence of the Disability and proof of financial dependence is sent to the Fund Office no later than 31 days after attainment of age 26.

  Proof that a Dependent Child over the age of 26 continues to meet the eligibility requirements for extension of benefits with this Plan may be required from time to time upon request.

If you meet the Plan's eligibility rules based on hours worked and are also eligible for coverage as a Dependent Spouse under this Plan, benefits will be payable to you both as a Participant and as a Dependent, in that order. In addition, both you and your Spouse may claim such benefits on behalf of your Children up to the maximum amounts provided under

this Plan, subject to the Plan's Coordination of Benefits rules. However, in no event will the total amount of benefits payable exceed 100% of the actual eligible charges incurred.

When Does Coverage Begin for your Dependents

Your Dependents become eligible for benefits on the date you become eligible for benefits. Although you will be enrolled for benefits automatically, your Dependents will not be covered until you provide applicable proof of Dependent Status and any applicable forms in accordance with the Enrollment provisions of the Plan. If you submit the applicable proof and any applicable forms within 30 days, your Dependents will be covered retroactively to the day you became covered. If, however, you submit the required paperwork more than 30 days after the date on which you became eligible for benefits, your Dependents will not be covered until the first day of the following month.

Notice to Plan of Loss of Dependent Status

You, your Spouse or your Dependent Child(ren), as applicable, **must notify the Plan preferably within 30 days but no later than 60 days** after the date a:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce); or
- Child ceases to meet the Plan's definition of Dependent (such as when a Child reaches the Plan's limiting age or when a Dependent Child above age 26 with a mental or physical handicap becomes capable of self-support).

Failure to give this Plan timely notice of loss of Dependent Status will cause your Spouse and/or Dependent Child(ren)to lose the right to obtain COBRA Continuation coverage. Further, you will be held liable for all claims paid by the Fund during any period of for which a Spouse or Dependent is not entitled to benefits.

Documenting your Hours

You have the right to inquire into your eligibility for participation and the level of your benefits under the Plan at any time.

If you believe you worked in covered Employment that was not properly credited under the Plan, you have the right to submit a claim in accordance with the claims procedures described later in this document. Please remember that, in the event of a discrepancy between the information and contributions received by the Fund from Contributing Employers and the contributions to which you believe you are entitled, it will be your responsibility to prove:

- The amount of work performed;
- That the work in question was actually performed by you for a Contributing Employer; and
- The work was covered Employment for which contributions were required to be made to the Fund.

Therefore, it is important that you retain adequate records of your covered Employment (for example, pay stubs, and other documentary evidence) that would help you prove both the amount of work you performed for each Contributing Employer and that the work constituted covered Employment. Please also remember that the longer you wait to file a claim to correct an issue, the more difficult it may be for you to provide, and for the Fund to verify, the necessary documentation.

The Fund generally determines both your initial and continuing eligibility based on the remittance reports submitted by Contributing Employers. While the Fund conducts regular payroll audits of Contributing Employers that sometimes provide information regarding the accuracy of remittance reports and other information submitted by employers, these audits may not reveal every instance in which a Contributing Employer may have failed to provide complete and/or accurate information concerning your employment.

ELIGIBILITY FOR RETIREE BENEFITS

Eligibility for Retiree Benefits

The Welfare Fund sponsors a separate, stand-alone Retiree Plan for Retirees who meet the eligibility rules described in this section. The Plan provisions as well as benefits are described in the Plumbers and Steamfitters Local 21 Welfare Fund Retiree Plan Summary Plan Description (Retiree SPD).

You may apply for Retiree Benefits when you retire from active coverage. You will be notified of your eligibility and if found to be eligible, will be sent the Retiree SPD and enrollment information. This information will also include an explanation of the current retiree self-pay premium requirements for coverage, if any.

Subject to payment of the Retiree self-pay amount (if you are under age 65), you are eligible for Retiree Benefits if you meet **ALL** of the following eligibility requirements:

- You are working in covered employment as a Journeyman, Steamfitter, Plumber or Apprentice of a Participating Employer or an active salaried employee of the Plumbers and Steamfitters Local Union No. 21 or its sponsored benefits funds; and
- You are eligible for Welfare Fund coverage as an Active Employee or as a Qualified Beneficiary under COBRA continuation coverage at the time of your retirement; and
- You have worked at least 1,000 hours in covered Employment in 15 or more separate calendar years; and
- During 2 of the 5 calendar years immediately preceding your retirement, you have worked at least 1,000 hours in covered Employment in each year.

Notwithstanding the above eligibility requirements, the Trustees may determine, in their sole discretion, whether a given calendar year's employment may be excluded from the eligibility assessment for Retiree Plan coverage based on the economic conditions within the geographic area and the Industry.

Eligibility for Disabled Retiree Benefits

If you become totally and permanently disabled, you may be eligible for Disabled Retire Benefits through the Retiree Plan. You are eligible for Retiree Benefits if you meet **ALL** of the following eligibility requirements:

- You become totally and permanently disabled while a Journeyman, Steamfitter, Plumber or Apprentice of a Participating Employer or an active salaried participant of the Plumbers and Steamfitters Local Union No. 21 or its sponsored benefits funds; and
- You obtain a disability award from Social Security and are granted a Disability Pension from the Plumbers and Steamfitters Local Union No. 21 Pension Fund; and
- You are eligible for Welfare Fund coverage either through active employment or COBRA continuation coverage as of the date of your disability and coverage is

maintained through the date your Disability Pension from the Plumbers and Steamfitters Local 21 Pension Fund commences; and

- You have satisfied one of the two following service requirements:
  - You have worked in each of the 5 calendar years immediately preceding the date of the Disability Pension, under the jurisdiction of the Plumbers and Steamfitters Local Union No. 21. During the 5-calendar year period, you must have worked for at least 800 hours in each calendar year prior to 2006 and at least 1,000 hours in 2006 and each calendar year after 2006; or
  - You have worked at least 1,000 hours in Covered Employment in 15 or more separate calendar years; and during 2 of the 5 calendar years immediately preceding your date of disability, you have worked at least 1,000 hours in covered Employment in each year.

Notwithstanding the above eligibility requirements, the Trustees may determine, in their sole discretion, whether a given calendar year's employment may be excluded from the eligibility assessment for Retiree Welfare Fund coverage based on the economic conditions within the geographic area and the Industry.

Note, for Disabled Retirees who do not become eligible for Medicare within 10 years of retirement, either by attaining age 65 or by virtue of disability, coverage under the Plan will terminate for the participant and all dependents after the 10th year of coverage under this Plan, including coverage following eligibility for Medicare.

Eligible Dependents

If you are eligible for Retiree coverage, then your Eligible Dependents are also eligible for Retiree benefits. Their benefits under the Retiree Plan begin when your coverage begins. However, your Dependents will still be subject to the self-pay provisions even if you are eligible for Medicare and no longer have a self-pay requirement for your coverage. The dependent self-pay amount will be based on the age your spouse, or if none, the age your Eligible Dependent will attain in the coming year. Please refer to the Retiree SPD for more information concerning self-pay premium requirements.

Note that for purposes of Retiree coverage, the definition of "Dependent Child" is different from that used for Active coverage. With respect to Retiree coverage, "Dependent Child" means:

Your unmarried Child who is dependent upon you for support and maintenance until the end of the year in which s/he attains her/his 19th birthday. If an unmarried Child is dependent upon you for support and maintenance and is attending an accredited school or college as a full-time student (registered for at least 12 credit hours), s/he will continue to be considered a Dependent under the Retiree Plan until the earliest of:

- The date s/he marries; or
- The end of the calendar year during which s/he ceases to be a full-time student (Note that a letter of full-time student status is required each semester to continue eligibility); or
- The end of the calendar year in which s/he attains her/his 23rd birthday.

Retiree Benefits and Opting-Out/Deferring Enrollment

At the time of retirement, or if later, the exhaustion of active eligibility, all eligible Retirees (and their Dependents) may elect to enroll in COBRA Continuation of Coverage (see *COBRA Continuation of Coverage* section of this booklet), the Retiree Plan when the Retiree first retires, or the Retiree Plan at a later date if they are covered by another group health plan and subsequently lose that other coverage. The rules for deferring enrollment in the Retiree Plan are described below.

Retirees and Dependents are eligible to decline/opt-out of Retiree Benefits and retain the right to re-enroll in the Retiree Plan at a later date, when they first retire or at any time thereafter if they have or become eligible for other group health coverage (for example, through a spouse) at the time they opt-out. To opt-out, Retirees must decline enrollment in the Retiree Plan in writing by submitting a completed Opt-Out Form to the Fund Office. The coverage waiver will be effective on the first of the month following the Fund Office's receipt of the completed Opt-Out Form. To re-enroll in the Retiree Plan, a Retiree must provide evidence of other group health coverage during the entire period the opt-out was effective within 30 days the date the other group health coverage terminates. If the proper documentation and enrollment materials are submitted within 30 days of termination of the other group health coverage, the coverage for the retiree and any Dependents will be effective retroactively to the date of loss. However, if a retiree does not re-enroll in the Retiree Plan within 30 days after loss of the other group health coverage, the retiree and any Dependents will not be allowed to re-enroll in the Retiree Plan at a later date.

Retiree Benefits and Eligibility for Medicare

The Retiree Plan provides benefits for retirees and Dependents that are not yet eligible for Medicare similar to that of the Active medical plan. Once a retiree or Dependent reaches age 65, or otherwise becomes eligible for Medicare, the Retiree Plan provides a plan designed for Medicare eligible retirees.

Retirees and Dependents that are age 65 or over, or otherwise become eligible for Medicare, must enroll in Medicare Part B when they first become eligible. Untimely enrollment in Medicare Part B will cause a break in coverage and jeopardize future eligibility in the Retiree Plan. However, a retiree or Dependent may delay enrollment in Medicare and still qualify for coverage under this Retiree Plan if and only if the delay was due to enrollment in other group health coverage. If a Retiree delays enrollment in Medicare Part B for any other reason, that Retiree would not be eligible to enroll in the Retiree Plan after retirement.

Under no circumstance will a Medicare eligible Retiree be eligible to enroll him or herself or any Medicare eligible Dependent if the concerned person is not covered under another group health plan or Medicare Part A/B (or Medicare Advantage), if applicable.

When Does Coverage Begin for Retirees

Retiree coverage does not begin until all hours earned as an active participant have been exhausted, and the retiree properly enrolled in the Retiree Plan.

The Fund Office will provide all necessary paper work to enroll in the Retiree Plan (the necessary forms and applicable premium amounts) upon initial retirement. Please return the all completed documentation promptly to the Fund Office to ensure that there is no break in your coverage.

When a Retiree Returns to Covered Employment

If a Retiree satisfies the initial eligibility requirement for active employees after retirement, benefits will be provided under the terms of the Active Plan. Retiree Benefits will be suspended for the period in which you are eligible for benefits under the Active Plan. See the *Eligibility* section of this booklet for more details on eligibility for active employees. When benefits under the Active Plan cease, Retirees will be reinstated to the appropriate Retiree Benefits. You will also be eligible to purchase COBRA Continuation Coverage when your active coverage ends. See the *COBRA Continuation Coverage* section of this booklet for more information.

ENROLLMENT

How to Enroll

When you first become eligible for benefits, the Fund Office will notify you and automatically enroll you for coverage. To enroll your Eligible Dependents, you must complete an enrollment form and submit it to the Fund Office together with any applicable proof of Dependent Status in accordance with the Enrollment provisions of the Plan. The Fund Office will accept a copy of any of the following documents as proof of Dependent Status:

- **Spouse:** copy of the certified marriage certificate and social security card.
- **Child:** copy of the certified birth certificate and social security card.
- **Stepchild:** copy of the certified divorce decree **and** copy of the biological parent's and Participant's certified marriage certificate **and** copy of the certified birth certificate and social security card.
- **Adoption or placement for adoption:** court order signed by the judge.
- **Disabled Dependent Child:**
  - A signed statement from the child's physician indicating the child is: Disabled (as defined in this document – see the *Eligibility* section of this booklet); that the Disability existed prior to age 26; and incapable of self-sustaining employment as a result of the Disability; **and**
  - Proof of support and maintenance, including a copy of your income tax return showing you claim the Child as a Dependent on IRS tax forms in compliance with the IRS Code 152 (a).

If for any reason you wish to disenroll an otherwise Eligible Dependent, you may do so at any time upon written request to the Fund Office. Please note, however, an Eligible Dependent may only be re-enrolled following disenrollment during December of each year, or if applicable, at another time and manner as described below.

Special Enrollment

If you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your Dependent(s). You must contact the Fund Office and submit an enrollment form together with applicable proof of Dependent Status within 30 days of the event. If you submit the enrollment form within 30 days, coverage will be effective as follows:

- Your Spouse (and any eligible step-children) will be covered retroactive to the date of your marriage.
- Your newborn biological child(ren) and adopted newborn(s) will be covered from the date of birth.

- Your adopted Dependent Child(ren) will be covered from the date the child(ren) is/are adopted or "placed for adoption" with you, whichever is earlier. 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.

  A child who is placed for adoption with you within 31 days after the child is born will be covered from birth if 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.

- Your newly adopted Dependent Child or Dependent Child Placed for Adoption who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

If you are declining enrollment for your dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll your Dependents in this plan at a later date if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

If your enrollment documentation is received after 30, 31 or 60 days, as applicable, coverage will begin when the Fund Office receives your completed enrollment forms together with applicable proof of Dependent Status. To request special enrollment or obtain more information call the Fund Office at (914) 737-7220.

Qualified Medical Child Support Order (QMCSO)

Federal Law requires group health plans, such as the Plan, to honor Qualified Medical Child Support Orders ("QMCSOs"). In general, QMCSOs are state court (or administrative agency) orders requiring a parent to provide medical support to a child, for example, in cases of legal separation or divorce where the child would otherwise not be eligible for coverage under the plan.

A QMCSO may require the Fund to make coverage available to your child even though, for income tax or Fund purposes, the child is not your dependent due to divorce or legal

separation. In order to qualify as a QMCSO, the medical child support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- specifies your name and last known address, and the child's name and last known address;
- provides a reasonable description of the type of coverage to be provided by the Fund, or the manner in which the type of coverage is to be determined;
- states the period to which it applies; and
- specifies each plan to which it applies.

The QMCSO may not require the Fund to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan. Upon approval of a QMCSO, the Fund is required to pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the Plan.

You and the affected child will be notified if an order is received and will be provided with a copy of the Fund's QMCSO procedures. A child covered under the Fund pursuant to a QMCSO will be treated as a Dependent under the Fund. Furthermore, you and your dependents can obtain, without charge, a copy of such procedures from the Fund Administrator.

TERMINATION OF COVERAGE

Termination of your coverage

Unless otherwise stated, your coverage under this Plan will terminate upon the earliest of the:

- end of the Benefit Quarter in which you have insufficient hours in the preceding 6- or 12-month Work Period to be eligible for the next Benefit Quarter;
- date this Plan terminates;
- date you are no longer a participant under this Plan;
- date you fail to pay the required self-payment, if any, when due; or
- date you are not ready willing and able to work for a Participating Employer (for reasons other than illness or disability).

Termination of your Dependent's coverage

The termination date of your Dependent's coverage will be the earliest of the date:

- your coverage terminates unless you die, as described below;
- your Dependent enters military or similar service anywhere;
- you and your Spouse are legally divorced; or
- your Dependent no longer meets the eligibility requirements of Dependent of the Plan (as described in the *Eligibility* section of this booklet).

In the Event of your Death

If you die while covered by the Fund, your Eligible Dependent(s) will be able to continue the benefits they were enrolled in immediately prior to your death. These benefits will continue until the later of (1) six months; or (2) the end of the month in which you would have had insufficient hours to continue your coverage for another month. Coverage for your Dependents may end earlier if one of the following occurs:

- your Dependent no longer meets the eligibility requirements of Dependent of the Plan
- Dependent coverage is no longer offered as part of the Plan; or
- your Dependent becomes covered as a Participant.

Notice of Termination

When your and/or your Dependent(s)'s coverage terminates, you and/or your Dependent(s) will be eligible to continue coverage as described in the *COBRA Continuation Coverage* section of this booklet. Upon termination, affected persons will receive a COBRA Qualifying Event Notice. The Notice will state the date on which coverage terminated.

Keep this Qualifying Event Notice in a safe place because you may need it if you decide to apply for Marketplace coverage instead of electing COBRA.

Retroactive Rescission of coverage

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that claim. Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of material fact to the Plan.

Coverage for you (the Participant) and/or your Dependents may be terminated retroactively (rescinded):

- In cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30-day notice);
- Due to non-payment of premiums (including COBRA premiums). Failure to notify the Plan of a loss of dependent status for any dependents (including divorce or legal separation or a child aging out of the Plan or a child no longer meeting the definition of Disabled child) constitutes a failure to pay COBRA premiums. In these situations, coverage may and will be terminated retroactively to the date of the event (without advanced notice).

If coverage is terminated, you may be required to repay to the Fund amounts incorrectly paid by the Fund. The Board of Trustees may commence legal action against a Participant or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the Participant or dependent to recover amounts owed.

LEAVES OF ABSENCE

Your coverage may continue during certain approved leaves of absence explained below.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period for:

- the birth, adoption, or placement with you for adoption of a child;
- providing care for a Spouse, child, or parent who is seriously ill;
- your own serious illness; or
- qualifying exigencies arising out of the fact that the active Participant's Spouse, son, daughter, or parent is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation.

The Family and Medical Leave Act (FMLA) allows you to take up to 24 weeks of unpaid leave during any 12-month period to provide care for a "covered service" member.

A Participant who is a Spouse, son, daughter, parent, or next of kin of a member of the Armed Forces, including a member of the National Guard or Reserves, may take leave up to 24 weeks to care for a member of the Armed Forces who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. An eligible active Participant is limited to a combined total of 24 workweeks of leave for any FMLA-qualifying reason during the "single 12-month period." (Only 12 of the 24 weeks total may be for a FMLA-qualifying reason other than to care for a covered service member.)

During your leave, you can continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for a leave under the FMLA if you:

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

The Fund will maintain your eligibility status until the end of the leave, provided the contributing Employer properly grants the leave under the FMLA and the contributing Employer makes the required notification and payment to the Fund. Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your covered dependents, the same as to active Participants and their covered dependents. If you do not return to covered Employment after your leave ends, you are entitled to COBRA continuation coverage when your leave ends. Call your Employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

USERRA Continuation coverage for Military Leave

A Participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

USERRA Continuation coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the Participant elects USERRA temporary continuation coverage, the participant (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.
- If the Participant goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.

Duty to Notify the Plan

The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the Participant in writing that they have been called to active duty in the uniformed services. The Participant must notify the Plan Administrator (contact information is contained in the Chart in the section of this booklet entitled *When you Have Questions About your Benefits* in the front of this document) as soon as possible but no later than 60 days after the date on which the Participant will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage

Once the Plan Administrator receives notice that the Participant has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Participant (and any eligible dependents covered under the Plan on the day the leave started). USERRA generally works in the same way as COBRA except that unlike COBRA continuation coverage, if the Participant does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the Participant (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and

that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same time frames as is permitted under COBRA.

Paying for USERRA Coverage

- If the Participant goes into active military service for up to 31 days, the Participant (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the Participant continues to pay the appropriate contributions for that coverage during the period of that leave
- If the Participant elects USERRA temporary continuation coverage, the Participant (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.
- USERRA allows you to apply your accumulated eligibility under this Plan toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When your accumulated eligibility is exhausted, you may pay for USERRA coverage under the self-pay rules of this Plan. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you can choose to freeze your accumulated eligibility and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan. You should contact the Fund Office to discuss your options.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. 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 this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces

When the Participant is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or

- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the Participant is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The Participant must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the Participant's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

If you have any questions about taking a leave of absence, please speak directly with your Employer. If you have any questions about how a leave of absence affects your coverage, please contact the Fund Office. Your USERRA rights are subject to change. coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Reinstatement of coverage After Leaves of Absence

If your coverage ends while you are on an approved FMLA leave or USERRA military leave, your coverage will be reinstated on the day you return to active employment (see the Military Leave section above for more details).

COBRA CONTINUATION OF COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your covered Dependents to continue health care coverage at your own expense under certain circumstances (called "qualifying events" as described below) when health care coverage would otherwise end. Your COBRA rights are subject to change and coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered dependents may continue the same coverage that you had before the COBRA-Qualifying Event, including Medical, Prescription drug, Vision, EAP, and HRA coverage. Under the law, only "qualified beneficiaries" are entitled to elect COBRA coverage. Depending on the type of qualifying event, a qualified beneficiary can include any Participant or Eligible Dependent who is covered by the Plan when a qualifying event occurs. Qualified beneficiaries have the same rights as active Participants or Eligible Dependents including special enrollment rights. A child who becomes an Eligible Dependent by birth, adoption, or placement for adoption with the Eligible Participant during a period of COBRA coverage is also a Qualified Beneficiary. A person who becomes your Spouse during a period of COBRA coverage is not a Qualified Beneficiary.

Alternatives to COBRA

You may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

You should note that when you retire, you have the option of electing COBRA continuation coverage instead of retiree medical coverage. If you do not elect COBRA continuation coverage when you first retire within the timeframes described in the COBRA Election Notice, you will no longer have any rights to COBRA continuation coverage, even when you lose your Retiree coverage. However, if your spouse and/or dependent child(ren) who are covered under the Retiree Plan experience a COBRA qualifying event while receiving Retiree coverage (for example, if you die or get divorced), they will be entitled to continue the Retiree coverage in accordance with COBRA for a period of up to 36 months from the date of the loss of Retiree coverage.

COBRA Eligibility (COBRA-Qualifying Events)

Duration of COBRA Coverage

Your COBRA coverage can continue for up to 18, 29 or 36 months depending on the COBRA-Qualifying Event as listed below. The COBRA continuation coverage period begins on the date you and/or your covered dependents lose coverage (rather than on the date of the Qualifying Event).

COBRA coverage May Continue For:	If the Following Event Occurs and coverage is Lost because:	Maximum Length Of COBRA coverage:
you and your Eligible Dependents	• your employment ends (for example, you resign for any reason except gross misconduct) • you work too few hours to remain eligible to for coverage under the Fund	18 months (29 months if you and your eligible dependents are Social Security-disabled*) from the loss of coverage due to the qualifying event.
your Eligible Dependents Only	• you die • you and your Spouse are divorced • you become entitled to Medicare and voluntarily drop Fund coverage • your child(ren) no longer qualifies as an eligible dependent under the Plan	36 months from the loss of coverage due to the qualifying event.

*** See "COBRA coverage In Case of Social Security Disability" for more details.**

How COBRA coverage Works

The following is the name, address and telephone number of the organization responsible for administering COBRA continuation coverage for the Fund:

Plumbers and Steamfitters Local 21 Welfare Fund
COBRA Continuation Coverage
1024 McKinley St.
Peekskill, NY 10566
(914) 737-7220

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to the Fund Office for your records.

Providing Notice of Qualifying Events

The Fund Office should be notified of your death, termination of employment, reduction in hours, retirement or entitlement to Medicare. However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification.

The Fund Office will determine the time period in which your employer must notify the Fund Office of your death, termination of employment, reduction in hours, retirement or Medicare entitlement. COBRA Continuation coverage will begin to run from the date of your loss of coverage and not the date of the Qualifying Event.

You and/or a family member are responsible for providing the Fund Office with timely notice of the following Qualifying Events:

- The divorce of a covered Participant from his or her Spouse;
- A beneficiary ceasing to be covered under the plan as a dependent child of a Participant; and
- The occurrence of a second Qualifying Event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second Qualifying Event could include a Participant's death, entitlement to Medicare, divorce or child losing Dependent Status.

In addition to these Qualifying Events, there are two other situations where you and/or a family member must provide the Fund Office with notice within the timeframe noted in this section:

- When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage; and
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled. In addition to these Qualifying Events, there are two other situations where you and/or a family member must provide the Fund Office with notice within the timeframe noted in this section:

You must make sure that the Fund Office is notified of any of these five occurrences listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How Should A Notice Be Provided?

Notice of any of the five situations listed above must be sent to the Fund Office in writing. You may use the Fund's "COBRA Notice Form for covered Employees and Qualified Beneficiaries" to provide notice to the Fund. You may obtain a copy of this form by calling the Fund Office at 914-737-7220 or by fax at (914) 737-7283. Alternatively, you may send a letter to the Fund Office containing your name, which one of the five qualifying events (described in the previous paragraph you are providing notice), the date of the event, the date in which you and/or your covered Dependent(s) will lose coverage. You should also include the necessary supporting documentation (e.g., the signature page of the divorce decree, copy of dependents birth certificate, Medicare Card, death certificate, etc.).

When Should the Notice Be Sent?

If you are providing notice due to a divorce, a dependent losing eligibility for coverage or a second qualifying event, you must send the Notice no later than **60 days after the later of** (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security Administration determination that you are **no longer** disabled, Notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a Summary Plan Description (SPD) or a general (initial) notice by the Plan.

Who can Provide a Notice?

Notice may be provided by the covered participant, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if a Participant, the Participant's Spouse and the Participant's child(ren) are all covered by the Plan, and the child ceases to become a dependent under the Plan, a single notice sent by the Spouse would satisfy this requirement.

If the notice has not been received by the Fund by the end of the applicable period described above, you and/or your Spouse and/or your dependent child(ren) will not be entitled to choose/extend COBRA Continuation coverage. Once you have provided notice, the Fund will send you information about COBRA coverage.

How to Elect COBRA Continuation Coverage

When your health care coverage ends because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Plan, you die, become entitled to Medicare, or when the Fund Office is notified that a Dependent Child lost Dependent Status, you are divorced, the Fund Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation coverage.

Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to enable you and/or them to apply for COBRA Continuation coverage.

Each qualified beneficiary with respect to a particular Qualifying Event has an independent right to elect COBRA continuation coverage. One or more covered dependents may elect COBRA even if the Participant does not. For example, both the Participant and the Participant's Spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for minor child(ren). In order to elect COBRA Continuation coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS AFTER RECEIVING NOTICE, YOU AND/OR THEY WILL HAVE NO GROUP HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDED.

COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for *COBRA Continuation Coverage* that appears later in this chapter for information about how much COBRA Continuation coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active Participants and their families, that same change will apply to your COBRA Continuation coverage.

Note: Since life insurance is not a health benefit, life insurance is not offered as a part of COBRA Continuation coverage.

COBRA Coverage in Cases of Social Security Disability

If you, your Spouse or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to an additional 11 months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage;
- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration; and
- The Fund is notified by you or your eligible dependent that the determination was received before the 18-month COBRA continuation period ended.

This extended period of COBRA coverage will end at the earlier of:

- 30 days after Social Security has determined that you and/or your eligible dependent(s) are no longer disabled;

- the end of the 29 month period from the date of the loss of coverage due to the COBRA-Qualifying Event; or
- the date the disabled individual becomes entitled to Medicare.

Cost of COBRA coverage in Cases of Social Security Disability

If the 18-month period of COBRA continuation coverage is extended because of Social Security Disability, the Fund will charge participants and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, or become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

This extended period of COBRA Continuation coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered Participant) during the 18-month period of COBRA Continuation coverage.

In no case is a Participant whose employment terminated or who had a reduction in hours entitled to COBRA Continuation coverage for more than a total of 18 months (unless the Participant is entitled to an additional period of up to 11 months of COBRA Continuation coverage on account of Social Security disability). As a result, if a Participant experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation coverage for more than a total of 36 months (except for Retirees who become entitled to COBRA Continuation coverage because of a Chapter 11 bankruptcy reorganization proceeding on the part of Employer).

Notice of Unavailability of Coverage

Where you or your dependents have provided notice to the Fund Administrator of a divorce, beneficiary ceasing to be covered under the plan as a dependent, or a second qualifying event but are not entitled to COBRA, the Fund Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same timeframe that the Fund is required to provide an election notice.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

The amount you, your covered Spouse, and/or your covered dependent child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active Participants and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended COBRA coverage due to Social Security disability. See the section entitled *Cost of COBRA Coverage in Cases of Social Security Disability* below for further information.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. Please note, the Fund office will not provide monthly invoices for the COBRA premiums. The cost of COBRA Continuation coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA Continuation coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. **If payment of the amount due is not made by the end of this grace period, your COBRA coverage will terminate effective the last day of the month for which premiums were paid.**

If the Fund Office has not received your COBRA payment by the due date (the first of the month), your COBRA coverage will be cancelled on the first day of the month. However, if your COBRA premium is paid within the 30-day grace period coverage will be reinstated back to the first day of that COBRA coverage period. Payment is considered made when it is postmarked.

When COBRA Coverage Ends

Your COBRA coverage ends on the earliest of the date that:

- The COBRA period (18, 29, or 36 months) ends.
- Any of the events listed below:
    - The date on which the Fund no longer provides group health coverage to any Participants;

- The first day of the time period for which the amount due for the COBRA Continuation coverage is not paid on time;
- The date, after the date of the COBRA election, on which the covered person first become entitled to (enrolled in) Medicare (usually 65);
- The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan:
- The date the plan has determined that the covered person must be terminated from the plan for cause: or
- If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed to be no longer disabled.

Notice of Termination of COBRA

If continuation coverage is terminated before the end of the maximum coverage period, the Fund Administrator will send you a written notice as soon as practicable following the Fund Administrator's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

If you Have Questions

Questions concerning the Plan or your COBRA coverage rights should be addressed to the Fund Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Alternative Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period," which is explained in the *Enrollment* section of this booklet. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see

what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I Enroll in Marketplace Coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

LIFE INSURANCE BENEFITS

Eligibility

You are eligible for the Life Insurance and Accidental Death and Dismemberment (AD&D) benefits if you are a Journeyman, Steamfitter, Plumber or Apprentice of a Participating Employer who meets the hours worked requirements as described under the *Eligibility* section of this booklet or an active salaried employee of the Plumbers and Steamfitters Local Union No. 21, the Plumbers and Steamfitters Local Union No. 21 Pension Fund or the Plumbers and Steamfitters Local No. 21 Welfare Fund. Your eligibility for Life Insurance coverage terminates when your Plan coverage terminates. Your Dependents are also eligible for Life Insurance coverage at a lesser level than the Member (but not AD&D coverage) and your Dependents' eligibility for Life Insurance coverage terminates when his or her Plan coverage terminates.

Benefit Schedule

The Fund's Life Insurance benefit is insured by Mutual of Omaha. In the event of your death from any cause, while you and/or your dependent(s) are covered and upon the Fund's receipt of complete proof of death, the named beneficiary will be entitled to receive a Life Insurance benefit. The Life Insurance Schedule of Benefits is as outlined below.

Eligible Person	Life Insurance Benefit
Active Participant	$20,000
Eligible Dependents 14 Days and Older	$1,000

Naming a Beneficiary

It's important that you name a beneficiary for your Life Insurance benefits. You may name anyone you wish as your beneficiary by filing the appropriate form at the Fund Office. Further, you may name more than one beneficiary to receive the proceeds of your Life Insurance coverage. You can change your beneficiary or beneficiaries at any time by filing a new form, that is signed and dated. The written request to change your beneficiary must be sent to the Fund Office within 30 days of the date you sign the new request. The beneficiary on file at the Fund Office at the time of your death is the one who will receive the proceeds of your Life Insurance coverage.

If you intend to have multiple beneficiaries, you must indicate whether a beneficiary is primary, secondary or shared. If you name more than one person, but do not indicate what their shares should be, they will share the benefit equally. If someone you name as a beneficiary dies before you, that person's share will be divided equally by the beneficiaries still alive, unless you indicate otherwise.

If there is no beneficiary designated or no surviving beneficiary at your death, the life insurance company will pay the benefit to your survivors according to the following order:

1. your Spouse if alive;
2. your child(ren), in equal shares, if there is no surviving Spouse;
3. your parent(s), in equal shares, if there is no surviving child;
4. your sibling(s), in equal shares, if there is no surviving parent;
5. your estate, if there is no surviving sibling.

If your beneficiary is a minor or incompetent to receive payment, the life insurance company would pay the beneficiary's guardian.

Form of Payment

The proceeds of your Life Insurance coverage are paid in one lump sum.

Dependent Life Insurance Benefit

Life insurance is provided for your Eligible Dependents 14 days and older in the amounts shown in the Schedule of Benefits. If your Dependent dies, the life insurance proceeds will be payable to you.

Filing a Claim and Proof of Death

If you die while covered, proof of your death should be given to the Fund Office promptly. Proof of your death is a certified copy of your death certificate and any other data the Plan Administrator may require to establish the validity of the claim for this benefit.

Living Benefits

If you become inured or sick with a terminal condition while you are eligible for Life Insurance coverage, you or your Dependents may request living benefits. For purposes of the living benefit, "terminal condition" means an injury or sickness that is expected to result in your death within the next 12 months as certified by an attending Physician's written statement.

You may request living benefits in any $1,000 subject to the following limitations. The maximum amount of Living Benefits available is 50% of the amount of life insurance in effect at the time of the request or $10,000, whichever is less. The minimum amount of Living Benefits that may be requested is 25% of the amount of life insurance in effect for you at the time of the request.

Living benefits are paid to you in a lump sum, provided you are living at the time payment is made. If you receive living benefits, the amount of life insurance benefits payable for you in the event of death will be reduced by the amount of living benefits paid for you. Life insurance on Dependents, if any, is not affected by payment of living benefits to you.

To receive living benefits, you must submit to the Fund Office:

- A written request for living benefits;
- Satisfactory proof of your terminal condition, including an attending physician's written statement; and
- A statement of consent from any beneficiary(ies) or assignee(s).

If you receive living benefits, the amount of insurance you may obtain under the conversion provisions will be reduced by the amount of living benefits paid to you.

Additional Information Regarding your Life Insurance Benefit

See the Certificate of Insurance from the life insurance company for information or details regarding:

- Portability Privilege;
- Your Extended Life Benefit with Waiver of Premium;
- Living Benefits;
- Converting your Group Term Life Insurance;
- Discontinuation of Insurance; and
- Exclusions.

NOTE: This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Overview of the AD&D coverage

The Fund's AD&D coverage pays benefits to you in the event you sustain a covered injury or paralysis as a result of an accident, provided the injury or paralysis occurs within 365 days of the accident. The AD&D coverage also pays benefits to your named beneficiary or beneficiaries in the event of your accidental death. For purposes of the Fund's AD&D coverage, accident means a sudden, unexpected, unforeseeable and unintended event, independent of sickness and all other causes. The AD&D benefits are insured by Mutual of Omaha and are available to you in addition to any other benefits you may receive in connection with an injury, paralysis or death.

Naming a Beneficiary for Accidental Death Benefits

You may name any person (or persons) as your beneficiary (or beneficiaries) for accidental death benefits. To do so, you must complete a beneficiary designation form and submit it to the Fund Office. If you intend to have multiple beneficiaries, you must indicate whether a beneficiary is primary, secondary or shared. If you name more than one person, but do not indicate what their shares should be, they will share the benefit equally. If someone you name as a beneficiary dies before you, that person's share will be divided equally by the beneficiaries still alive, unless you indicate otherwise. You may change your beneficiary (or beneficiaries) at any time. To do so, you must complete a new beneficiary designation form and submit it to the Fund Office. Only the beneficiary (or beneficiaries) named on the most recent beneficiary designation form on file with the Fund Office at the time of your death will be entitled to receive payment of accidental death benefits. If there is no beneficiary designated or no surviving beneficiary at your death, the insurance company will pay the benefit to your survivors according to the following order:

1. your Spouse, if alive;
2. your child(ren), in equal shares, if there is no surviving Spouse;
3. your parent(s), in equal shares, if there is no surviving child;
4. your sibling(s), in equal shares, if there is no surviving parent;
5. your estate, if there is no surviving sibling.

If your beneficiary is a minor or incompetent to receive payment, the life insurance company would pay the beneficiary's guardian.

For more information about naming a beneficiary, see the *Life Insurance Benefit* section of this booklet.

Filing a Claim for AD&D Benefits

After you sustain a covered loss (injury, paralysis or death), you or your beneficiary must file a notice of claim with the Fund Office within 20 days after the loss occurs or as soon

as reasonably possible thereafter so that your eligibility for benefits can be verified. Once it is determined that you are eligible for benefits, the Fund Office will send you a claim form. You must complete and sign the claim form and, if applicable, have a physician complete and sign the relevant portion of the form as well. You should then return the completed claim form to the Fund Office or Mutual of Omaha within 90 days after the loss occurs or as soon as reasonably possible thereafter but not later than one year after the loss occurs.

Payment of AD&D Benefits

Depending on the type of loss, the maximum benefit payable is $20,000. Benefits will be paid in a lump sum to either you, in the case of injury or paralysis, or your beneficiary (or beneficiaries), in the case of death, in accordance with the AD&D Benefit Schedule below. At any time prior to loss, you may elect periodic payments in lieu of a lump sum payment by submitting a written request to the Fund Office.

Benefit Schedule

Loss	**Benefit**
Life Both Hands Both Feet Entire Sight of Both Eyes One Hand and One Foot One Hand and Entire Sight of One Eye One Foot and Entire Sight of One Eye Speech and Hearing (both ears)	$20,000
Entire Site of One Eye Speech or Hearing (both ears) One Hand or One Foot	$10,000
Loss of Thumb and Index Finger of Same Hand	$5,000
Coma	Monthly Percentage of $20,000
Paralysis	**Benefit**
Quadriplegia *Total paralysis of both upper and lower limbs*	$20,000
Triplegia *Total paralysis of three limbs*	$15,000
Paraplegia *Total paralysis of both lower limbs* Hemiplegia *Total paralysis of an upper and lower limb*	$10,000
Uniplegia *Total paralysis of a limb*	$5,000

Other Benefits	Benefit
Airbag Benefit	$2,000
Seatbelt Benefit	$2,000

Airbag Benefit

If you are injured in an automobile accident in which an airbag deploys and that injury results in your death, Mutual of Omaha will pay your beneficiary or beneficiaries $2,000. A copy of the police accident report must be submitted with the claim to prove your death resulted from an automobile accident and that the airbag deployed at the time of the accident. This benefit is in addition to the benefit payable for loss of life. No Airbag Benefits are payable if the automobile accident occurs when you are not seated directly behind an airbag or during a professional race, stunt or exhibition work.

Seatbelt Benefit

If you are injured in an automobile accident while wearing a seat belt, and that injury results in your death, Mutual of Omaha will pay your beneficiary or beneficiaries $2,000. A copy of the police accident report must be submitted with the claim to prove your death resulted from an automobile accident and that you were wearing a seat belt at the time of the accident. This benefit is in addition to the benefit payable for loss of life. No Seat Belt Benefits are payable if the automobile accident occurs when you are not wearing a seat belt or during a professional race, stunt or exhibition work.

Exclusions

No AD&D benefit is payable for any loss that:

1. Results from an intentionally self-inflicted injury or sickness; or suicide or attempted suicide;
2. Results from your participation in a riot or in the commission of a felony;
3. Results from an act of declared or undeclared war;
4. Is incurred while you are on active duty in the Armed Forces, national Guard or Reserves or any state or country and for which any governmental body or its agencies are liable;
5. Occurs more than 365 days after injury;
6. Does not result from an accident;
7. Results from injuries you receive in any aircraft while operating, riding as a passenger, boarding or leaving, except that this exception does not apply while you are riding as a passenger in a commercial aircraft on a regularly scheduled flight or while traveling on business for Plumbers and Steamfitters Local 21;

8. Results in injuries you receive while riding in any aircraft engaged in racing, endurance tests, or acrobatic or stunt flying;

9. Is caused by you and is a result of injuries you receive while under the influence of any controlled drug, unless administered on the advice of a physician; or

10. Is caused by you and is a result of injuries you receive while intoxicated.

NOTE: This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern.

MEDICAL BENEFITS

Using your PPO

How the Medical Program Works

The Fund provides comprehensive coverage for a wide variety of medical conditions and treatments. Your benefits include coverage for:

- Facility services including hospital inpatient, outpatient and emergency room services.
- Professional services including medical care provided by physicians and ancillary providers such as physical therapist, chiropractor, registered nurses and other licensed healthcare providers.

All participants who have satisfied the eligibility requirements of the Fund, and their covered Dependents, are eligible for Medical benefits outlined in this section. However, there are some limitations on coverage. You should refer to the *Services Subject to Preauthorization, Schedule of Benefits* and *Exclusions* sections for a list of services and supplies that are have limits or are not covered by this Plan.

Benefits are provided for Covered Services under the terms and conditions of this Plan only when the covered Service is:

- Medically Necessary;
- Listed as a covered Service;
- Not in excess of any benefit limitations described in the *Schedule of Benefits* section of this booklet; and
- Received while you are eligible for benefits under this Plan.

You may need to request Preauthorization before you receive certain services. See the *Services Subject to Preauthorization* section of this Booklet for the services that require Preauthorization.

Empire BlueCross BlueShield administers the Medical program in addition to the Preferred Provider Organization (PPO) described in this section. The Empire PPO provides you with the freedom to choose any Provider; however, your choice of Providers will determine how and the level in which your benefits are paid. Benefits provided by In-Network or Participating Providers will be paid at a higher benefit level than benefits provided for an Out-of-Network Provider or Non-Participating. The amount of Cost-Sharing (or how much you pay out of your own pocket) applicable to specific services and supplies and Providers is outlined in the *Schedule of Medical Benefits* which also describes where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to In-Network and Out-of-Network services.

This Plan does not have a gatekeeper, usually known as a Primary Care Physician (PCP). You do not need a referral from a PCP before receiving Specialist care.

Know the Basics

The key to using your PPO plan is understanding how benefits are paid. Start by choosing In-Network or Out-of-Network providers for services any time you need healthcare. Your choice determines the level of benefits you will receive. If you do not know whether your Provider is In-Network, you can call the number on your Empire ID card or visit www.empireblue.com. You can also request a directory of providers from Empire.

Use your PPO to Your Best Advantage

Knowing how to use your PPO 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 is covered by the plan. That way, you and your doctor are better able to make decisions about your healthcare. Empire can 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.
- Remember to obtain preauthorization for hospital admissions and certain treatments and procedures. Precertification gives you and your doctor an opportunity to learn what is covered under the Plan and identify treatment alternatives and the proper setting for care – for instance, a hospital, outpatient facility or your home. Knowing these things in advance can help you save time and money. If you fail to obtain preauthorization when necessary, your benefits may be reduced or denied.
- Ask questions about your healthcare options and coverage. To find answers, you can:
  - Call the Fund Office when you have questions about your benefits in general. You should contact Empire Member Services for questions about coverage for specific medical services or supplies or to get information about specific Providers.
  - Talk to your provider about your care, learn about your benefits and your options, and ask questions. Empire is available to work with you and your provider to see that you get the best benefits while receiving the quality healthcare you need.

Accessing Care. To make an appointment, call your physician's office, have your Member ID card available and tell them the reason for your visit. They may ask you for your group number, member I.D. number, or office visit copay or coinsurance. 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.

Choosing In-Network or Out-of-Network Services

In-Network Benefits

In-Network benefits provide the highest level of coverage available. In-Network benefits apply when care is provided by In-Network, or Participating Providers, who contract directly with Empire. The level of In-Network benefits is indicated in the Schedule of Benefits. You should always consider receiving health care services first from In-Network providers.

Participating Providers. To find out if a Provider is a Participating Provider, and for details about licensure and training check your Provider directory, available at your request, or call the number on your Empire ID card or visit www.empireblue.com. You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. You can also request that a directory be mailed to you free of charge by contacting Empire at 1-800-342-9816, 1-800-810-BLUE (2583) or the Fund Office. Sometimes Providers in Empire's Provider directory are not available. You should always call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

BlueCard Worldwide® Program. If you plan to travel outside the United States, call Empire 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. The Plan only covers Emergency Services, including ambulance and Urgent Care outside of the United States. Remember to take a current Empire 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 may call them collect at 804-673-1177.

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 at the time of service are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for doctors services, inpatient hospital care not arranged through BlueCard Worldwide and outpatient services at the time of service. You will also need to file a claim form for any payments made at the time of service. When you need BlueCard Worldwide claim forms, you can get international claim forms by calling the BlueCard Worldwide Service Center at (800) 810-2583 or online at www.bluecardworldwide.com.

Out-of-Network Benefits

The Out-of-Network benefits provide coverage when you receive Covered Services from Out-of-Network or Non-Participating Providers. Out-of-Network services are healthcare services provided by a licensed provider outside Empire's PPO network or the BlueCard PPO networks of other BlueCross and/or BlueShield plans. These providers do not have contracted fees or rates for Covered Services.

For most services, you can choose In-Network or Out-of-Network. However, some services are only available In-Network. When you use Out-of-Network services you pay an annual deductible and coinsurance, plus any amount above the maximum Allowed Amount (the maximum Empire will pay for a covered service). This is sometimes known as "balance billing." Amounts you pay an Out-of-Network provider for "balance billing" can be significant and do not count toward your deductible or out-of-pocket maximum. However, if you use a BlueCard provider, you will pay only the lower of billed charges or a negotiated rate and your applicable cost-sharing. In addition, you will may have to pay the provider immediately upon receiving Out-of-Network care and may need to file a manual claim with Empire for reimbursement.

Services Subject to Preauthorization

Preauthorization is required before you receive certain Covered Services. You are responsible for requesting Preauthorization for the services listed below. Note that in many cases, your In-Network provider may handle the Preauthorization on your behalf.

- All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns that exceed 48 hours for a normal delivery or 96-hours for a cesarean section;
- Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification;
- Skilled Nursing Facility;
- Outpatient/Ambulatory Surgical Treatments (certain procedures);
- Physical*, Occupational*, and Speech Therapy;
- Diagnostics;
- Outpatient Treatments;
- Air Ambulance;
- High tech radiology services including but not limited to MRIs and MRAs;
- Durable Medical Equipment*;
- Prosthetics* and Orthotics*

*Preauthorization not required when services obtained Out-of-Network.

Preauthorization/Notification Procedure. If you seek coverage for services that require Preauthorization, you or your Provider must call Empire at the number on your ID card. The procedures for obtaining Preauthorization or notification are described below.

- At least two (2) weeks prior to a planned admission or surgery when your Provider recommends inpatient hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-emergency condition.

You must contact Empire to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If you are hospitalized in cases of an Emergency Condition, you must call Empire within 48 hours after your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, Empire will review the reasons for your planned treatment and determine if and at what level benefits are available. Criteria will be based on multiple sources, which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Failure to Seek Preauthorization or Provide Notification. If you fail to seek Preauthorization or provide notification for benefits as required in this section, the Fund will pay only 50% of the amount the Fund would otherwise have paid for the care, up to $5,000. You will be responsible for the remaining charges. The Fund will pay the amount specified above only if it is determined that the care was Medically Necessary even though you did not seek Preauthorization or provide notification. However, if the Fund determines that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service. The penalty listed above will not apply to Medically Necessary inpatient Facility services from a BlueCard Provider.

Medical Management. The benefits available to you under this Plan are subject to pre-service, concurrent and retrospective reviews to determine whether and when services should be covered by the Fund. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

Medical Necessity. The Plan covers 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 the Plan will cover it.

Medical Necessity may be based on a review of:

- Your medical records;
- Empire's 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; and
- The opinion of Health Care Professionals in the generally-recognized health specialty involved.

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 or 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, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or in the home setting.

See the *Claims and Appeals Procedures* section of this booklet for information on your right to appeal when a claim for benefits is denied.

Delivery of Covered Services Using Telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to you while your location is different than your Provider's location. If your Provider offers Covered Services using telehealth, the Fund will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the booklet that are at least as favorable as those requirements for the same service when not delivered using telehealth.

Case Management. Case management helps coordinate services for participants with health care needs due to serious, complex, and/or chronic health conditions. Case Management programs coordinate benefits and provide education to those who agree to take part in the case management program to help meet their health-related needs.

Empire's case management programs are confidential and voluntary. These programs are given at no extra cost to you and do not change Covered Services. If you meet program criteria and agree to take part, Empire will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Physician(s), and other Providers. In addition, Empire may assist in coordinating care with existing community-based programs and services to meet your needs, which may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Fund may provide benefits for alternate care through Empire's case management program that is not listed as a covered Service. The Fund may also extend Covered Services beyond the benefit maximums of this Plan.

Nothing in this provision shall prevent you from appealing a decision. A decision to provide extended benefits or approve alternate care in one case does not obligate the Fund to provide the same benefits again to you or to any other Member. The Fund reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Fund or its authorized representative will notify you or your authorized representative in writing.

Cost-Sharing Expenses and Allowed Amount

Summary of Cost Sharing Provisions		
Cost-Sharing Type	**In-Network/Participating Provider Participant Responsibility for Cost-Sharing**	**Out-of-Network/Non-Participating Provider Participant Responsibility for Cost-Sharing***
Deductible		
Except where stated otherwise, you must pay the Deductible for Covered Services during each Benefit Period (January 1 – December 31) before the Plan provides coverage. If you have other than individual coverage, the individual Deductible applies to each person covered under this Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Benefit Period. After Deductible payments for covered persons collectively total the family Deductible, no further Deductible will be required for any family member for that Benefit Period. Note that Cost-Sharing for Out-of-Network services applies toward your In-Network Deductible. Cost-Sharing for In-Network services does not apply toward your Out-of-Network Deductible. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.		
• **Individual**	**$250**	**$2,500**
• **Family**	**$625**	**$6,250**
Copayment		
After you have satisfied the Deductible as described above, you must pay the Copayments, or fixed amounts for In-Network benefits as shown in the *Schedule of Benefits*. However, when the Allowed Amount for a service is less than the Copayment, you are only responsible for the lesser amount**.**		
• **Telemedicine**	**NO CHARGE**	**N/A**
• **Primary Care Visits**	**$20**	**N/A**
• **Specialist Office Visits**	**$40**	**N/A**
• **Urgent Care Visits**	**$35**	**N/A**
• **Emergency Room Visits**	**$200**	**$200**
Coinsurance		
After you have satisfied the Deductible described above, you must pay a percentage of the Allowed Amount for Covered Services for Out-of-Network services and most In-Network services other than office and emergency room visits. The Plan will pay the remaining percentage of the Allowed Amount as your benefit. See the *Schedule of Benefits* for details.		
• **Coinsurance Percentage**	**10%** (Generally, only applicable when a copayment does not apply)	**30%** (You will also have to pay any balances above the Allowed Amount)
Out-of-Pocket Limit		
When you have met your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period, the Plan will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Benefit Period. If you have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Booklet, the Fund will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for that person. If other than individual coverage applies, when persons in the same family covered under this Plan have collectively met the family Out-of-Pocket Limit, the Fund will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for the entire family. Note that a separate Out-of-Pocket Limit applies to Prescription Drug benefits. Cost-Sharing for Out-of-Network services does apply toward your In-Network Out-of-Pocket Limit, however Cost-Sharing for In-Network services does not apply towards your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the *How Your Coverage Works* section of this Booklet does not apply toward your In-Network Out-of-Pocket Limit.		
• **Individual**	**$3,000**	**$9,000**
• **Family**	**$7,500**	**$25,000**

***Your Additional Payments for Out-of-Network Benefits**

When you receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the *Schedule of Benefits*, you must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds the Allowed Amount. This means that the total of the Plan's payment and any Cost-Sharing amounts you pay may be less than the Non-Participating Provider's actual charge.

When you receive Covered Services from a Non-Participating Provider, Empire will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services you received. Sometimes, applying these rules will change the way that Empire will pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. Empire will make one inclusive payment in that case rather than a separate payment for each billed code.

Another example of when Empire will apply the payment rules to a claim is when you have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If Empire receives a claim that does not have the correct modifier, they will change it and make the appropriate payment. Additionally, another example of when they will apply a payment rule to a claim is when you receive services from a Health Care Professional who is not a Physician, such as a physician's assistant. Under the payment rule, the Allowed Amount for a physician's assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.

Allowed Amount

"Allowed Amount" means the maximum amount the Plan will pay for the services or supplies covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. Empire determines the Allowed Amount as follows:

- The Allowed Amount for Participating Providers will be the amount Empire has negotiated with the Participating Provider, or the amount approved by another Host Plan, or the Participating Provider's charge, if less.
- The Allowed Amount for Non-Participating Providers will be determined as follows:
    - For Facilities, the Allowed Amount will be the average amounts paid by Empire for comparable services to Empire's Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Empire for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.

- For all other Providers, the Allowed Amount is 150% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type, unadjusted for geographic locality.

The Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed the Allowed Amount. You must pay the difference between the Allowed Amount and the Non-Participating Provider's charge. Empire reserves the right to negotiate a lower rate with Non-Participating Providers or to pay another Host Plan's rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually. See the Emergency Services section of this Booklet for the Allowed Amount for an Emergency Condition.

Schedule of Benefits

Benefit	Participating Provider Participant Responsibility/Cost-Sharing	Non-Participating Provider Participant Responsibility/Cost-Sharing
DEDUCTIBLE • **Individual** • **Family**	 **$250** **$625**	 **$2,500** **$6,250**
OFFICE VISITS		
Primary Care Office Visits (or Home Visits)	$20 Copayment not subject to Deductible	30% Coinsurance after Deductible
Specialist Office Visits (or Home Visits)	$40 Copayment not subject to Deductible	30% Coinsurance after Deductible
PREVENTIVE CARE (Please see Preventive Care Section below for more details of specific coverage)		
• Well Child Visits and Immunizations	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Adult Annual Physical Examinations	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Adult Immunizations	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Routine Gynecological Services/Well Woman Exams	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Mammography Screenings	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Sterilization Procedures for Women	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Vasectomy	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Bone Density Testing	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Screening for Prostate Cancer	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• All other preventive services required by USPSTF and HRSA.	Covered in full not subject to Deductible	30% Coinsurance after Deductible
When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service
EMERGENCY CARE (Please see Ambulance and Pre-Hospital Emergency Medical Services and Emergency Services and Urgent Care Sections below for more details of specific coverage)		
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Non-Emergency Ambulance Services	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Emergency Department Out-of-Network covered same as In-Network for an Emergency Condition • Copayment waived if Hospital admission	$200 Copayment not subject to Deductible	$200 Copayment not subject to Deductible
Urgent Care Center	$35 Copayment not subject to Deductible	30% Coinsurance after Deductible

Benefit	Participating Provider Participant Responsibility/Cost-Sharing	Non-Participating Provider Participant Responsibility/Cost-Sharing
DEDUCTIBLE • **Individual** • **Family**	 **$250** **$625**	 **$2,500** **$6,250**
PROFESSIONAL SERVICES and OUTPATIENT CARE (Please see Outpatient and Professional Services Section below for more details of specific coverage)		
Acupuncture Unlimited visits per Benefit Period	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Advanced Imaging Services		
• Performed in an Office Setting	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Freestanding Radiology Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Allergy Testing and Treatment		
Testing		
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Treatment		
• Performed in a PCP Office	Covered in full not subject to Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	Covered in full not subject to Deductible	30% Coinsurance after Deductible
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Anesthesia Services (all settings)	 10% Coinsurance after Deductible	 30% Coinsurance after Deductible
Autologous Blood Banking	Use Cost-Sharing for appropriate Service	30% Coinsurance after Deductible
Cardiac Rehabilitation Unlimited visits per Benefit Period		
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing
Chemotherapy		
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Chiropractic Services		
• Performed in Specialist Office	$40 Copayment not subject to Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Clinical Trials	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service

Benefit	Participating Provider Participant Responsibility/Cost-Sharing	Non-Participating Provider Participant Responsibility/Cost-Sharing
DEDUCTIBLE • **Individual** • **Family**	 **$250** **$625**	 **$2,500** **$6,250**
Diagnostic Testing		
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Dialysis		
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Freestanding Center	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Care 200 visits per Benefit Period	10% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
Infusion Therapy		
• Performed in a PCP Office	10% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
• Performed in a Specialist Office	10% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
• Home Infusion Therapy Home Infusion provided by Home Health Agency counts toward Home Health Care visit limits	10% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
Inpatient Medical Visits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Laboratory Procedures		
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Freestanding Laboratory Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Maternity and Newborn Care		
• Global fee for the prenatal/postnatal and delivery services – Maternity visits	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefit	Participating Provider Participant Responsibility/Cost-Sharing	Non-Participating Provider Participant Responsibility/Cost-Sharing
DEDUCTIBLE • **Individual** • **Family**	 **$250** **$625**	 **$2,500** **$6,250**
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
Physician and Midwife Services for Delivery	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Postnatal Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Inpatient Hospital Services and Birthing Center • One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early	Included as part of Inpatient Hospital service Cost-Sharing	30% Coinsurance after Deductible
• Breast Pump One (1) breast pump per pregnancy for the duration of breast feeding	Covered in full not subject to Deductible	30% Coinsurance after Deductible
Outpatient Hospital Surgery *Facility Charge*	 10% Coinsurance after Deductible	 30% Coinsurance after Deductible
Preadmission Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Pulmonary Rehabilitation		
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diagnostic Radiology Services		
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Freestanding Radiology Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Therapeutic Radiology Services		
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed in a Freestanding Radiology Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical Therapy 30 visits per Benefit Period		
• Performed in a PCP Office	$20 Copayment not subject to Deductible	Not covered
• Performed in a Specialist Office	$40 Copayment not subject to Deductible	Not covered
• Performed as Outpatient Hospital Services	$40 Copayment not subject to Deductible	Not covered
Occupational and Speech Therapies 30 combined visits per Benefit Period		
• Performed in a PCP Office	$20 Copayment not subject to Deductible	Not covered

Benefit	Participating Provider Participant Responsibility/Cost-Sharing	Non-Participating Provider Participant Responsibility/Cost-Sharing
DEDUCTIBLE • **Individual** • **Family**	 **$250** **$625**	 **$2,500** **$6,250**
• Performed in a Specialist Office	$40 Copayment not subject to Deductible	Not covered
• Performed as Outpatient Hospital Services	$40 Copayment not subject to Deductible	Not covered
Second Opinions on the Diagnosis of Cancer, Surgery and Other Second opinions on diagnosis of cancer are covered at Participating Cost-Sharing for Non-Participating Specialist when authorization is obtained		
• Performed in a PCP Office	$20 Copayment not subject to Deductible	30% Coinsurance after Deductible
• Performed in a Specialist Office	$40 Copayment not subject to Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)		
• Inpatient Hospital Surgery	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Outpatient Hospital Surgery	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Surgery Performed at an Ambulatory Surgical Center	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Surgery Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Surgery Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Telemedicine Program		
• Performed by *www.livehealthonline.com*	Covered in full not subject to Deductible	Not covered
Vision Therapy		
• Performed in a Specialist Office	$40 Copayment not subject to Deductible	Not covered
• Performed as Outpatient Hospital Services	$40 Copayment not subject to Deductible	Not covered
ADDITIONAL SERVICES, EQUIPMENT and DEVICES (Please see Outpatient and Professional Services Section below for more details of specific coverage)		
Diabetic Equipment, Supplies and Self-Management Education		
Diabetic Equipment, Supplies and Insulin	See Prescription Drug Benefit	See Prescription Drug Benefit
Diabetic Education		
– Performed in a PCP Office	$20 Copayment not subject to Deductible	30% Coinsurance after Deductible
– Performed in a Specialist Office	$40 Copayment not subject to Deductible	30% Coinsurance after Deductible
– Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment and Braces	10% Coinsurance after Deductible	Not covered
Hospice Care 210 days per lifetime		

Benefit	Participating Provider Participant Responsibility/Cost-Sharing	Non-Participating Provider Participant Responsibility/Cost-Sharing
DEDUCTIBLE • **Individual** • **Family**	 **$250** **$625**	 **$2,500** **$6,250**
• Inpatient	10% Coinsurance after Deductible	Not covered
• Outpatient	10% Coinsurance after Deductible	Not covered
Medical Supplies		
• Performed in an Office Setting or by a third-party supplier	10% Coinsurance after Deductible	Covered same as In-Network
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Orthotics	10% Coinsurance after Deductible	Not covered
Prosthetic Devices	10% Coinsurance after Deductible	Not covered
Wigs	10% Coinsurance after Deductible	Not covered
INPATIENT SERVICES and FACILITIES (Please see Inpatient Services Section below for more details of specific coverage)		
Inpatient Hospital for a Continuous Confinement	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Skilled Nursing Facility 60 days per Benefit Period	10% Coinsurance after Deductible	Not covered
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 30 days per Benefit Period	10% Coinsurance after Deductible	30% Coinsurance after Deductible
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES (Please see Mental Health and Substance Use Disorder Services Section below for more details of specific coverage)		
Inpatient Mental Health Care		
• Continuous confinement when in a Hospital	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Mental Health Care Treatment Unlimited visits		
• Performed in a PCP or Specialist Office	$20 Copayment not subject to Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance not subject to Deductible	30% Coinsurance after Deductible
Inpatient Substance Use Treatment		
• Continuous confinement when in a Hospital	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Substance Use Treatment Unlimited visits		
• Performed in a PCP or Specialist Office	$20 Copayment not subject to Deductible	30% Coinsurance after Deductible
• Performed as Outpatient Hospital Services	10% Coinsurance not subject to Deductible	30% Coinsurance after Deductible

The following describes the benefits the Plan covers as part of the Empire PPO in detail. Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Preventive Care

The following services are covered for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Empire at the telephone number on your ID card or visit Empire's website at *www.empireblue.com* for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

- **Well-Baby and Well-Child Care.** Well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the Bright Future/American Academy of Pediatrics. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per calendar year, we will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunization vaccines and boosters as required by ACIP are also covered for children from birth to age 18. Doses recommended ages, and recommended populations must be satisfied.
- **Adult Annual Physical Examinations.** Adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

  Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, lung cancer screening, colorectal cancer screening and diabetes screening.

  You are eligible for a physical examination once every year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.
- **Adult Immunizations.** Routine adult immunizations as recommended by ACIP for

participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation. Doses, recommended ages and recommended populations must be satisfied.

- **Well-Woman Examinations.** Well-woman examinations which begin in adolescence and continue across the lifespan for delivery of required preventive services including but not limited to routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

- **Mammograms.** Mammograms for the screening of breast cancer as follows:

  - One (1) baseline screening mammogram for women age 35 through 39; and
  - One (1) baseline screening mammogram annually for women age 40 and over.

  If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, the Plan covers mammograms as recommended by her Provider. However, in no event will more than one (1) preventive screening per Plan Year be covered.

  Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

- **Family Planning and Reproductive Health Services.** Family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug Benefits section of this Booklet, counseling on use of contraceptives, and related topics, and sterilization procedures for women as prescribed by a health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing. The Plan also covers vasectomies. The Fund does not cover services related to the reversal of elective sterilizations.

- **Bone Mineral Density Measurements or Testing.** Bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Benefits section of this Booklet. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if you meet any of the following:

  Previously diagnosed as having osteoporosis or having a family history of osteoporosis;

  - With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
  - On a prescribed drug regimen posing a significant risk of osteoporosis;

- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

The Plan also covers bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

- **Screening for Prostate Cancer**. 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. The Plan also covers 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.

Ambulance and Pre-Hospital Emergency Medical Services

Emergency Ambulance Transportation. Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition are covered when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. The Plan will, however, only cover transportation to a Hospital provided by such 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 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from you for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

Emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed, Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide are covered.

Non-Emergency Ambulance Transportation. 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 a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

Limitations/Terms of coverage

- Travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Empire, even though prescribed by a Physician is not covered.
- Non-ambulance transportation such as ambulette, van or taxi cab are not covered.
- 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 (1) of the following is met:
  - The point of pick-up is inaccessible by land vehicle; or
  - Great distances or other obstacles (e.g., heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

Emergency Services and Urgent Care

Emergency Services. Emergency Services are covered for the treatment of an Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not you are in the Service Area at the time your Emergency Condition occurs:

- **Hospital Emergency Department Visits.** In the event that you require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are covered in an emergency department**. The Plan does not cover follow-up care or routine care provided in a Hospital emergency department.
- **Emergency Hospital Admissions.** In the event that you are **admitted** to the Hospital, you or someone on your behalf must notify Empire at the number on your Empire ID card within 48 hours of your admission, or as soon as is reasonably possible. The Plan covers inpatient Hospital services at a non-participating Hospital at the In-Network Cost-Sharing for as long as your medical condition prevents your transfer to a participating Hospital.

Any inpatient Hospital services received from a non-participating Hospital after your medical condition no longer prevents your transfer to a participating Hospital will be covered at the Out-of-Network Cost-Sharing unless Empire authorizes continued treatment at the non-participating Hospital.

If your medical condition permits your transfer to a participating Hospital, Empire will notify you and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after Empire has notified you and arranged for a transfer to a participating Hospital will be covered at the Out-of-Network Cost-Sharing.

Payments Relating to Emergency Services Rendered. The amount the Plan pays a Non-Participating Provider for Emergency Services will be the greater of: 1) the amount Empire has negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount the Plan would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

If a dispute involving a payment for physician services is submitted to an independent dispute resolution entity ("IDRE") Empire will pay the amount, if any, determined by the DRE for physician services. You are responsible for any In-Network Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed your Copayment, Deductible or Coinsurance.

- **Urgent Care.** Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is covered in or out of the Empire Service Area on an In-Network or Out-of-Network basis. If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

Outpatient and Professional Services

The Plan covers the following outpatient and professional services. Please refer to the *Schedule of Benefits* for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

- **Acupuncture.** Acupuncture services rendered by a Health Care Professional licensed to provide such services.
- **Advanced Imaging Services.** PET scans, MRI, nuclear medicine, and CAT scans.
- **Allergy Testing and Treatment.** Testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. The Fund also covers allergy treatment, including desensitization treatments, routine allergy injections and serums.

- **Ambulatory Surgical Center Services.** Surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.
- **Chemotherapy.** Chemotherapy in an outpatient Facility or in a Health Care Professional's office.
- **Chiropractic Services.** Chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions contained in this booklet.
- **Clinical Trials.** 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 sections of this Booklet.

  The Plan does 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 the 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.
- **Dialysis.** Dialysis treatments of an Acute or chronic kidney ailment.
- **Home Health Care.** Care provided in your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:
  - Part-time or intermittent nursing care by or under the supervision of a registered professional nurse; and
  - Part-time or intermittent services of a home health aide; and

- Physical, occupational, or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been covered during a Hospitalization or confinement in a Skilled Nursing Facility

Home Health Care is limited to 200 visits per Benefit Period. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services benefits.

- **Infusion Therapy.** Infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward your home health care visit limit.
- **Interruption of Pregnancy.** Therapeutic abortions including abortions in cases of rape, incest or fetal malformation (i.e., medically necessary abortions). The Fund covers elective abortions.
- **Laboratory Procedures, Diagnostic Testing and Radiology Services.** X-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.
- **Maternity and Newborn Care.** Services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. Includes prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. The Plan will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section for coverage of inpatient maternity care. The cost of renting or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding.
- **Medications for Use in the Office.** Medications and injectables (excluding self-injectables) used by your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when your Provider orders the Prescription Drug and administers it to you.

  When Prescription Drugs are covered under this benefit, they will not be covered under the Prescription Drug Benefits section of this booklet.

- **Office Visits.** Office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.
- **Outpatient Hospital Services.** Hospital services and supplies as described in the Inpatient Services section of this Booklet that can be provided to you while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.
- **Preadmission Testing.** Preadmission testing ordered by your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:
  - The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
  - Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
  - Surgery takes place within seven (7) days of the tests; and
  - The patient is physically present at the Hospital for the tests.
- **Rehabilitation Services.** Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to the number of visits listed on the Schedule of Benefits section of this Booklet.
- **Second Opinions.**
  - **Second Cancer Opinion.** A second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an In-Network basis when your attending Physician provides a written authorization to a non-participating Specialist.
  - **Second Surgical Opinion.** A second surgical opinion by a qualified Physician on the need for surgery.
  - **Required Second Surgical Opinion.** Empire may require a second opinion before it preauthorizes a surgical procedure. There is no cost to you when Empire requests a second opinion.
    - The second opinion must be given by a board certified Specialist who personally examines you.
    - If the first and second opinions do not agree you may obtain a third opinion.
    - The second and third surgical opinion consultants may not perform the surgery on you.

- **Second Opinions in Other Cases.** There may be other instances when you will disagree with a Provider's recommended course of treatment. In such cases, you may request that Empire designates another Provider to render a second opinion. If the first and second opinions do not agree, Empire will designate another Provider to render a third opinion. After completion of the second opinion process, Empire will preauthorize Covered Services supported by a majority of the Providers reviewing your case.

- **Surgical Services.** Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

  Sometimes two (2) or more surgical procedures can be performed during the same operation.

  - **Through the Same Incision.** If covered, multiple surgical procedures are performed through the same incision, the procedure with the highest Allowed Amount is payable.
  - **Through Different Incisions.** If covered, multiple surgical procedures are performed during the same operative session but through different incisions, Empire will pay:
    - For the procedure with the highest Allowed Amount; and
    - 50% of the amount that would otherwise be payable for the other procedures.

- **Oral Surgery.** The following limited dental and oral surgical procedures are covered:
  - Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
  - Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
  - Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
  - Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
  - Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

- **Reconstructive Breast Surgery.** Breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by you and your attending Physician to be appropriate. Implanted breast prostheses following a mastectomy or partial mastectomy are also covered.
- **Other Reconstructive and Corrective Surgery.** Reconstructive and corrective surgery other than reconstructive breast surgery only when it is:
    - Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
    - Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
    - Otherwise Medically Necessary.
- **Telemedicine Program.** In addition to providing Covered Services via telehealth, the Plan covers online internet consultations between you and Providers who participate in Empire's telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Empire's telemedicine program. You can check Empire's Provider directory or contact Empire for a listing of the Providers that participate in the telemedicine program.

  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.

  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.

  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 request precertification for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

- **Transplants.** Only those transplants determined to be non-experimental and non-investigational are covered. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

  All transplants must be prescribed by your Specialist(s). Additionally, all transplants must be performed at Hospitals that Empire has specifically approved and designated to perform these procedures.

  The Hospital and medical expenses are covered, including donor search fees, of the Member-recipient. Transplant services required by you when you serve as an organ donor are only covered if the recipient is a Member. The medical expenses of a non-Member acting as a donor for you are not covered if the non-Member's expenses will be covered under another health plan or program.

  To maximize your benefits, you should call Empire's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. Empire will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Empire Member Services number on the back of your Empire ID card and ask for the transplant coordinator. Even if Empire gives a prior approval for the covered Transplant Procedure, you or your Provider must call Empire's Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

  Precertification is required for a transplant. Your Doctor must certify, and Empire must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to Empire as soon as possible to start this process.

  Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

  The Fund does not cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

- **Vision Therapy.** Vision therapy to improve vision skills, such as eye movement control and eye coordination.

Inpatient Services

- **Hospital Services.** Inpatient Hospital services are covered for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:
  - Semiprivate room and board;
  - General, special and critical nursing care;
  - Meals and special diets;
  - The use of operating, recovery and cystoscopic rooms and equipment;
  - The use of intensive care, special care or cardiac care units and equipment;
  - Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
  - Dressings and casts;
  - Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
  - Blood and blood products except when participation in a volunteer blood replacement program is available to you;
  - Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
  - Short-term physical, speech and occupational therapy; and
  - Any additional medical services and supplies which are provided while you are a registered bed patient and which are billed by the Hospital.

  The Cost-Sharing requirements in the *Schedule of Benefits* apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.
- **Observation Services.** Observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge you. These services include use of a bed and periodic monitoring by nursing or other licensed staff.
- **Inpatient Medical Services.** Medical visits by a Health Care Professional on any day of inpatient care covered under the Plan.
- **Inpatient Stay for Maternity Care.** Inpatient maternity care in a Hospital for the

mother and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. Any additional days of such care are covered if Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, a home care visit will be covered. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Coverage of this home care visit shall be in addition to home health care visits under the Plan and shall not be subject to any Cost-Sharing amounts in the *Schedule of Benefits* that apply to home care benefits.

- **Inpatient Stay for Mastectomy Care.** Inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by you and your attending Physician.
- **Autologous Blood Banking Services.** Autologous blood banking services only when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, the Fund covers storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.
- **Rehabilitation Services.** Inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Coverage is limited to 30 days per Benefit Period.
- **Skilled Nursing Facility.** Services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in Hospital Services above. Custodial, convalescent or domiciliary care is not covered (see the "Exclusions and Limitations" section of this Booklet). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Empire. coverage for non-custodial care is limited to 60 days per benefit period.
- **End of Life Care.** If you are diagnosed with advanced cancer and you have fewer than 60 days to live, Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients is covered. Your attending Physician and the Facility's medical director must agree that your care will be appropriately provided at the Facility. If Empire disagrees with your admission to the Facility, they have the right to initiate an expedited external appeal to an External Appeal Agent. Empire will cover and reimburse the Facility for your care, subject to any applicable limitations in this Booklet until the External Appeal Agent renders a decision in the Plan's favor.

  Non-Participating Providers for this end of life care is reimbursed as follows:

  - A rate that has been negotiated between Empire and the Provider.

- If there is no negotiated rate, the Acute care at the Facility's current Medicare Acute care rate.
- If it is an alternate level of care, at 75% of the appropriate Medicare Acute care rate.

Limitations/Terms of coverage

- When you are receiving inpatient care in a Facility, additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies you take home from the Facility are not covered. If you occupy a private room, and the private room is not Medically Necessary, coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
- Radio, telephone or television expenses, or beauty or barber services are not covered.
- Any charges incurred after the day Empire advises you that it is no longer Medically Necessary for you to receive inpatient care are not covered.

Mental Health Care and Substance Use Services

Mental Health Care Services

- **Inpatient Services.** Inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under the Plan. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 (10), such as:
  - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
  - A state or local government run psychiatric inpatient Facility;
  - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
  - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; and,
  - In other states, to similarly licensed or certified Facilities.

  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 are also covered. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York

Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

- **Outpatient Services.** Outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

  Limitations/Terms of coverage

  No coverage is provided for the following:

  - Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
  - Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
  - Services solely because they are ordered by a court.

Substance Use Services

- **Inpatient Services.** Inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

  Inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges are also covered. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services and; and, in other states, to those Facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

- **Outpatient Services.** Outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization

program services, intensive outpatient program service, and methadone treatment. Such coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

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 after a vaginal delivery or less than 96 hours after 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 after a vaginal delivery or 96 hours for cesarean section. In any case, under federal law, health plans and health insurance issuers may not require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay in excess of 48 (or 96) hours.

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under 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;
- breast prosthesis and surgical bras following a masectomy; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Cost-Sharing applicable to other medical and surgical benefits provided under this plan.

Genetic Information Non-Disclosure Act (GINA)

Effective June 1, 2009, GINA prohibits discrimination by group health plans such as the Plan against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Plan is also prohibited from setting premium and contribution rates for the employer group on the basis of genetic information of an individual enrolled in the plan.

GINA requires the HIPAA Privacy regulations to be amended, effective May 21, 2009, to treat genetic information as protected health information. GINA prohibits the use of genetic information for underwriting purposes and makes the definitions of genetic information and underwriting consistent with GINA.

Exclusions and Limitations

The following services and/or supplies are not covered under the Empire PPO Medical benefits. No coverage is available under this Plan for the following:

- **Aviation.** Services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- **Convalescent and Custodial Care.** Services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.
- **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.
- **Cosmetic Services.** Cosmetic services or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. The Plan also covers services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Booklet. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to Utilization Review and Appeals sections of this booklet unless medical information is submitted.
- **Coverage Outside of the United States, Canada or Mexico.** Care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Urgent Care, Pre-Hospital Emergency Medical Services and ambulance services to treat your Emergency Condition.
- **Dental Services.** Dental services except for; care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Booklet.
- **Experimental or Investigational Treatment.** Any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, experimental or investigational treatments, including treatment for your rare

disease or patient costs for your participation in a clinical trial as described in the Outpatient and Professional Services section of this Booklet, or when denial of services is overturned by an External Appeal Agent certified by the State are covered. However, for clinical trials the Fund will not cover the costs of any investigational drugs or devices, 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 Plan for non-investigational treatments. See the Claims and Appeals Procedures section of this booklet for a further explanation of your Appeal rights.

- **Felony Participation.** Any illness, treatment or medical condition due to your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).
- **Foot Care.** Routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, The Fund will cover foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.
- **Government Facility.** Care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless you are taken to the Hospital because it is close to the place where you were injured or became ill and Emergency Services are provided to treat your Emergency Condition.
- **Medically Necessary.** Any health care service, procedure, treatment, test, device or Prescription Drug that it determines is not Medically Necessary.
- **Medicare or Other Governmental Program.** Services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When you are eligible for Medicare, benefits will be reduced by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if you fail to enroll in Medicare or you do not pay your Medicare premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if you are not eligible for premium-free Medicare Part A.
- **Military Service.** An illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- **No-Fault Automobile Insurance.** Any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.
- **Services Not Listed.** Services that are not listed in this Booklet as being covered.
- **Services Provided by a Family Member.** Services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of you or your Spouse.

- **Services Separately Billed by Hospital Employees.** Services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
- **Services with No Charge.** Services for which no charge is normally made.
- **Vision Services.** The examination or fitting of eyeglasses or contact lenses.
- **War.** Illness, treatment or medical condition due to war, declared or undeclared.
- **Workers' Compensation.** Services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits, administered by OptumRx, provide coverage for prescription drugs at retail pharmacies as well as through mail-order. The mail-order drug program provides home delivery for maintenance or long-term drugs at a reduced cost to you. The following provides a summary of what your prescription drug benefits are and how to use them. If you have any questions about your benefits, please reach out to the Fund Office or call OptumRx directly at (866) 863-1408.

You and your covered dependents will receive an ID card in the Member Participant's name from OptumRx. You will need this card in order to use your prescription drug benefits. If your ID card is lost, you can print a temporary card online at www.OptumRx.com. If there is an emergency, and you need a prescription filled, call OptumRx Member Services toll-free at (866) 863-1408 and they will provide your pharmacist with the required information to facilitate claim processing.

Summary of Prescription Drug Cost Sharing Provisions		
Cost-Sharing Type	**In-Network/Participating Pharmacy Participant Responsibility for Cost-Sharing**	**Out-of-Network/Non-Participating Pharmacy Participant Responsibility for Cost-Sharing**
Out-of-Pocket Limit When you have met your Out-of-Pocket Limit in payment of coinsurance for a calendar year, the Plan will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that calendar year. If you have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit shown below, the Fund will provide coverage for 100% of the Allowed Amount for the rest of that calendar year for that person. If other than individual coverage applies, when persons in the same family covered under this Plan have collectively met the family Out-of-Pocket Limit, the Fund will provide coverage for 100% of the Allowed Amount for the rest of that calendar year for the entire family. Note that a separate Out-of-Pocket Maximum applies to Medical Benefits. Please note that penalties and Cost-Sharing for Out-of-Network services does not apply toward your In-Network Out-of-Pocket Limit.		
• **Individual** • **Family**	**$3,520** **$8,800**	**Not applicable**
Coinsurance You must pay a percentage of the allowed prescription drug costs for covered formulary drugs. The Plan will pay the remaining percentage of the allowed prescription drug costs as your benefit. If you use a non-participating pharmacy, you will also be required to pay the difference between the actual cost of the drug and the amount allowed by the Plan. If you fill a prescription drug that is not covered on the formulary, you will pay the full cost of the drug.		
Coinsurance Percentage	20%	20%, **plus** difference between the actual cost of the drugs/supplies and the amount allowed by the Plan.
Diabetic Prescription Drugs and Supplies Diabetic prescription drugs and supplies, when provided by a participating pharmacy and covered under the formulary, are fully paid by the Plan. This means that you will to have to pay a copayment or coinsurance for your diabetic prescription drugs or supplies. If you fill your diabetic prescription at a non-participating pharmacy, you will still be responsible to pay the difference between the actual cost of the drugs/supplies and the amount allowed by the Plan. If you fill a diabetic prescription drug/supply that is not covered on the formulary, you will pay the full cost of the drug.		

Preventive Medicines

Preventive prescription drugs filled at a participating pharmacy are covered at no charge for the purpose of promoting good health and early detection of disease. This coverage is provided in accordance with the Affordable Care Act and include low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors, all FDA-approved contraceptive methods as prescribed by a health care provider, risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects and all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider. The Plan also covers a few over-the-counter drugs including low-dose aspirin and vitamin D if the applicable criteria is met for coverage.

In order to be covered at no charge, the prescription must be in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). The Plan only covers generic drugs (or single source drugs, when applicable) without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. In order for any over-the-counter drugs required to be covered by the ACA under this provision, a prescription must be presented in accordance with Plan rules. You may contact OptumRx at the telephone number on your ID card for more information about preventive prescription drugs covered at no charge.

Retail Pharmacies

Using a Participating Pharmacy

OptumRx has established a network of pharmacies through which you may fill prescriptions. If you use one of OptumRx's participating pharmacies, your out-of-pocket costs will usually be lower than if you use a non-participating pharmacy. The OptumRx network consists of pharmacies nationally, including many chain drugstores like CVS, Rite-Aid and Walgreens. To find a participating pharmacy in your area, contact OptumRx directly by phone at (866) 863-1408 or visit the OptumRx website at www.optumrx.com.

To obtain up to a 31-day supply of medicine, present your ID card to any participating retail pharmacy. When you use a participating retail pharmacy, you will be responsible to pay 20% of the cost of each prescription drug you purchase. While a participating pharmacy can usually check eligibility online through OptumRx, if you purchase a prescription at a participating pharmacy without your ID card, you might need to pay for the prescription and submit the prescription drug receipt to OptumRx for direct reimbursement.

Using a Non-Participating Pharmacy

When you use a non-participating pharmacy, you will be responsible to pay 20% of the cost of each prescription drug you purchase plus any difference in the cost of the prescription and the amount allowed by the Plan. If you use a non-participating pharmacy and/or pay the retail cost out-of-pocket for your Plan covered medication, you will have to submit a claim along with the prescription drug receipt to OptumRx for reimbursement. The amount reimbursed may be significantly lower than the retail price you paid; therefore, always try to use a participating network pharmacy and present your ID card to reduce any unnecessary out-of-pocket expenses.

Mail-order Service

The mail-order program is designed to be more convenient and less expensive for you to obtain drugs that you use on a long-term basis, and the medications are delivered directly to your home. You may use the mail order service to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as those that are prescribed for high blood pressure, diabetes, asthma, or similar long-term conditions. You are responsible for 20% of the cost of each prescription drug you purchase through the mail-order program (except for diabetic medications/supplies). Note: Not all medicines are available via mail order. Please contact the OptumRx Mail Order pharmacy at (877) 889-6358 or check with the Fund Office for further information.

For your first order:

- Ask your doctor to write the prescription for a 90-day supply, with the appropriate refills.
- Complete a mail-order form and mail it along with your prescription to:

  OptumRx
  P.O. Box 2975,
  Mission, KS 66201

Mail-order forms may be obtained from the Fund Office.

You can also have your physician submit your prescription electronically or fax your prescription to (800) 491-7997. Be sure that your physician includes the cardholder name, ID number, shipping address and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted.

OptumRx does NOT automatically refill your prescriptions. To order refills you have three options:

- Internet: Visit www.optumrx.com.
- Phone: Call Member Services toll-free, (877) 889-6358, 24 hours a day, 7 days a week and use the prompts to order your refills. Have your identification number and credit card information ready.

- Mail: Send the Refill Request Order Form provided with your last shipment back to the address below in the pre-addressed envelope.

  OptumRx
  P.O. Box 2975
  Mission, KS 66201

To avoid delays, always include the appropriate coinsurance or copayment (if applicable) when your order is placed. Visa, MasterCard, Discover or American Express and debit cards are accepted. You may also pay by check or money order, but please do not send cash. Please allow up to 2 weeks for delivery. Emergency prescriptions can be expedited at an additional charge.

Specialty Medication

Specialty medicines are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, or rheumatoid arthritis, and which require special distribution, handling, and administration. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medicines require an enhanced level of service.

This plan includes a mandatory specialty pharmacy requirement, meaning that all specialty medications must be ordered through the specialty pharmacy, BriovaRx Pharmacy. Please note that initial fills of specialty medications are limited to a 30-day supply. You are responsible for 20% of the cost of each prescription drug you purchase through the specialty pharmacy. For more information about the specialty pharmacy, please contact BriovaRx Pharmacy directly at (855) 427-4682 or contact the Fund Office.

To order refills you have two options:

- Phone: BriovaRx Pharmacy directly at (855) 427-4682 and please have your ID number and credit card information ready.
- Internet: Visit www.briovarx.com.

You can also have your physician submit your prescription electronically or fax your prescription to (877) 342-4596. Be sure that your physician includes the cardholder name, ID number, shipping address and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted.

To avoid delays, always include the appropriate copayment (if applicable) when your order is placed. Visa, MasterCard, Discover or American Express and debit cards are accepted.

Personalized Member Service and Consultation

Patients receiving medications through the specialty pharmacy are provided with a customized patient care plan designed by OptumRx's clinical team. Each patient is monitored individually to ensure their medication and dosage is appropriate and patients are adherent to their prescribed therapy.

The Specialty Pharmacy is responsible for the following:

- Contacting the prescriber for diagnosis for all new medications or the first fill at the Specialty Pharmacy
- Verifying member eligibility and identifying lower-cost alternatives that may be available
- Obtaining the member's age and weight in order to verify dosing based on the manufacturer's recommendations and current clinical guidelines
- Obtaining disease state information from the prescriber and member
- Documenting details gathered from the prescriber in the member's profile
- Consultation with prescribers regarding any potential issues that may be identified during the clinical drug utilization review (DUR)
- Counseling the patient on their medication usage
- Arranging for shipment of the medication and informing the member when the medication will arrive, making sure someone will be available to accept the shipment

Formulary

There are often several types of medications that can be used to treat the same condition. To ensure high-quality care and to help manage costs, the prescription drug program has a formulary that lists preferred or formulary drugs. **Only drugs listed on the formulary as covered are covered by the Plan.** As part of the formulary, various clinical and utilization management programs are employed in order to ensure the effective, safe and cost-conscious prescriptions are chosen. These programs are described in more detail below.

OptumRx frequently updates this formulary based on available therapies, costs, efficacies and alternatives. You will be notified by OptumRx of any change in the formulary and if it has any effect on medication you are taking. For more information about the formulary, please contact OptumRx directly at (866) 863-1408.

Utilization and Clinical Management Programs

Prior Authorization and Drug Quantity Management

Certain medications require prior authorization (PA) because of their potential side effects, potentially harmful interactions with other prescription medications or to confirm they are being prescribed in accordance with Food & Drug Administration (FDA) approved indications. This process is designed to help ensure your health and safety. If a PA is needed, OptumRx will work directly with your physician to obtain the necessary information prior to fulfillment. This process initiation can be requested by the member, pharmacist or the prescriber.

Drug quantity management is a program designed to limit the amount per prescription that can be dispensed at one time by number and/or pill dosage. This ensures you are taking

the correct amount that is considered safe and effective, according to guidelines from the U.S Food & Drug Administration (FDA).

The list of medications that require prior authorization or are limited in dosage and/or quantity are determined by OptumRx pursuant to its utilization management program and will change from time to time. Since OptumRx will modify this list from time to time, you should contact OptumRx to determine whether a particular medication is being managed. If you go to a participating pharmacy, medications affected by these programs will also be identified by OptumRx when you present the prescription. If you receive a prescription for one of the medications, you should consult with your physician or pharmacist to have them reach out to OptumRx at (866) 863-1408. If you fill a prescription without the required authorization or approval, your medication will not be covered.

Step Therapy

In a Step Therapy program, covered drugs are organized in a series of "steps". The Step Therapy program is generally geared towards patients who regularly take prescriptions to treat chronic conditions or who are prescribed a high-cost medication where preferred therapeutically equivalent alternatives are available. In order to ensure that an effective, safe and cost-conscious prescription is chosen, the Fund has implemented Step Therapy programs for certain drugs.

In essence, the Step Therapy program requires you to try the preferred alternatives prior to the more expensive prescription drug, unless your physician presents an acceptable medical reason for the more expensive drug or you have already tried the preferred drug and it was not effective. There are usually two "steps:" the step one preferred therapy and the step two non-preferred therapy.

If you have tried a step one medication and it doesn't work for you and your physician has documentation that you previously tried and failed a first-step medication, the physician, pharmacist or you can contact the OptumRx clinical team at (866) 863-1408 and request a review of the medication.

Formulary and Utilization Management Program Exception Process

In certain circumstances, there are exceptions to these formulary and management rules. Continued use of drugs that are not covered because of they are non-formulary, or are subject to the aforementioned management programs must be approved through OptumRx's exception process. The requests are evaluated on the basis of medical necessity, the individual's health and safety and the existence of other viable alternatives. If you or your physician would like to request an exception, you should contact OptumRx at (866) 863-1408. Please note that the exception process must be initiated by your physician.

Exclusions

Regardless of whether you receive service from a participating or non-participating pharmacy, the following drugs/services/supplies are not covered:

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e. are used "off-label") or are experimental and/or investigational.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin.
3. Naturopathic, naprapathic or homeopathic services and substances.
4. Drugs, medicines or devices for:
    - enhancement of athletic performance such as anabolic steroids;
    - hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa);
    - vitamin A derivatives (retinoids) for dermatologic use (i.e. Retin A, Renova).
5. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
6. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.
7. Any prescription drug or medicine not provided by the Plan's prescription drug program and formulary.
8. Self-help devices such as a scale, blood pressure cuff, peak flow meter, pill crusher, magnifying glass/device, etc.
9. Zolgensma to treat the genetic disorder, Spinal Muscular Atrophy (SMA) Type I.

The Board of Trustees will review the exclusions and drugs that require prior approval from time to time, in light of new drugs approved by the FDA and other considerations, and revise the list of covered and non-covered drugs based on criteria established by OptumRx. Please contact OptumRx for the most up-to-date information on which drugs are not covered by the Plan and those that require prior approval.

If you have any question regarding your program, please call OptumRx at (866) 863-1408.

VISION BENEFITS

The Plumbers and Steamfitters Local 21 Welfare Fund offers you and your Eligible Dependents vision benefits. You and your Eligible Dependents can receive a vision exam and lenses every year and new frames every (2) years based on the fee schedule. Eligible active Participants (Member Participants eligible under this Plan) are also covered for occupational lenses and frames (safety glasses) annually.

Vision benefits are self-funded separate from the self-insured medical plan and therefore considered excepted benefits under Affordable Care Act (ACA) and HIPAA regulations.

Network Providers

The vision benefits are provided through two networks of providers; Vision Resources and Vision Network. Network providers (optometrist or dispensing optician) have a contract to provide discounted fees to you for services covered under this Vision Benefit. By using the services of an In-Network provider, you will pay based on a negotiated fee schedule, which is generally less than an out-of-network. A list of network vision providers is available by calling the Fund Office. To receive services, simply call a Vision Resources or Vision Network provider and identify yourself as a Participant (or covered Dependent) of the Fund. Selections of frames and lenses may vary between the Vision Resources and Vision Network and, in some instances, between providers within the same network.

How to Obtain Optical Care from a Network Provider

If you need vision care, you must first call the Fund Office at (914) 737-7220. The Fund Office will provide you with an optical voucher and information about the two organizations that provide optical benefits. You may then present the optical voucher you receive from the Fund Office to a Vision Resources or Vision Network provider. You may also obtain a list of network providers by calling the Fund Office. Some services that you receive from participating providers require that you pay a portion of the cost. The services and their costs are listed in the Schedule of Vision Benefits below.

Out-of-Network Providers

You may also use a licensed optometrist and/or dispensing optician that does not participate with either of the vision plans. If you prefer to use a non-participating provider for your vision needs, the Plan will pay up to the benefit level that would have been paid to a Vision Resources participating provider. The itemized bill reflecting the Out-of-Network provider's fees must be submitted to the Fund Office for reimbursement. Out-of-Network provider services will usually cost you more than if those same services were obtained from an In-Network provider.

Schedule of Vision Benefits

Some services that you receive from participating providers require that you pay a portion of the cost. The Services and their costs are listed below. Please note that network

copays are covered by obtaining a voucher from the Fund Office. When you visit an Out-of-Network provider, allowed charges are reimbursed by the Fund up to the amount of the Out-of-Network allowance.

	Vision Network Copay	Vision Resources Copay	Out-of-Network Allowance
Exams			
New Patient Exam	No charge	$10.00	$55.00
Existing Patient Exam	No charge	$5.00	$50.00
Frames/Safety Frames	No charge for frames within selection	Varies depending on frame selected	$100.00
Contact Lenses	No charge for lenses within selection	Varies depending on lenses selected	$60.00
Spectacle Lenses			
Single Vision Lenses	No charge	$1.00	$29.00
Bifocal Lenses	No charge	$5.00	$46.00
Trifocal lenses	No charge	$22.50	$57.50
Occupational Trifocals	No charge	$22.50	$57.50
Progressive Lenses	No charge	$110.00	$60.00
Extras			
Scratch Resistant Coat	No charge	$6.00	$10.00
Plastic Solid Tint	No charge	None	$10.00
Plastic Gradient Tint	No charge	$5.00	$10.00
Glass-Photo Chromic			
Single Vision	No charge	$8.00	$22.00
Bifocal	No charge	$15.00	$25.00
Plastic Photo Chromic (transition)			
Single Vision	No charge	$18.50	$31.50
Bifocal	No charge	$45.00	$35.00

Filing a Vision Claim

When you use the services of an In-Network vision provider, you should pay the provider for your copay, if applicable, and those services not covered by the Vision Benefit. The provider will send the remainder of their bill directly to the Fund Office for reimbursement.

If you use the services of an Out-of-Network vision provider, you will need to pay the provider for all services and then complete and submit an Out-of-Network vision claim form along with the bill to the Fund Office. You will be reimbursed up to the amount allowed under the Vision benefits as noted in the Schedule of Vision Benefits. Vision claims submitted beyond one year of the date of service will not be considered for reimbursement.

See the *Claims and Appeals Procedures* section of this booklet for more information about filing claims and appealing denied claims.

Exclusions

The Vision Benefit is designed to cover visual needs and not cosmetic materials. When you select any of the following excluded services/supplies, the Plan will pay the cost of the allowed portion of the vision service/supply and the covered person will pay the additional cost.

1. Oversized lenses (larger than 61mm), laminated lenses, plano (non-prescription/no refractive power) lenses or orthokeratology lenses for reshaping the cornea of the eye to improve vision.
2. Vision services and supplies that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
3. Orthoptics (vision training to improve the visual perception and coordination of the two eyes), subnormal vision aids and any associated supplemental testing.
4. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
5. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
6. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK).
7. Services or materials provided as a result of any Workers' Compensation Law, or similar occupational health legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.
8. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
9. Vision check-ups or screenings required or requested by the participant's employer, school or government.
10. Experimental and/or investigational treatment or procedure.
11. Eye examinations or eyewear required as a condition of employment, except for the occupational safety glasses (as described in this section) for the active participant.
12. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.

LOWER HUDSON VALLEY BUILDING AND CONSTRUCTION TRADES EMPLOYEE ASSISTANCE PROGRAM (LHV-EAP)

The Lower Hudson Valley Building and Construction Trades Employee Assistance Program (LHV-EAP) is an organization of social workers, counselors and licensed psychologists that provides confidential, professional assistance to Participants and covered Dependents. LHV-EAP can help you with mental health problems, drug and alcohol abuse, marital and relationship issues, anger management, work performance issues, legal matters, financial stress, gambling problems, health concerns and other life stressors.

LHV-EAP services include:

- Crisis counseling until an appropriate referral to a health care provider can or should be made;
- Pre-diagnostic assessment to determine the type of referral necessary;
- Referral to an appropriate facility or health care provider;
- Back-to-work interviews and assessments as appropriate; and
- Follow-up on each case to determine further needs

To take advantage of the LHV-EAP, call (914) 245-6300 or (800) 327-2799. If you call during regular business hours, you will reach a counselor. When you call after hours, a trained operator will answer the phone and refer your case to a counselor who will promptly return your call. After discussing the problem and evaluating your particular needs, the counselor will arrange an appointment at the LHV-EAP or make a referral to an appropriate resource.

There is no charge to you when you call or visit the LHV-EAP. If you accept a referral for additional help for a mental health problem or drug or alcohol abuse, the charges of the health professionals or counselors to whom you are referred will, in most cases, be covered by the Plan. However, when non-medical assistance is required, e.g., legal, financial or community services, it is your responsibility to arrange for payment with these providers.

IMPORTANT: The LHV-EAP is a voluntary program offered to you in addition to any benefits provided by Empire BCBS for mental health and substance use disorder services. Although you are not required to use LHV-EAP services, LHV-EAP clinical specialists may coordinate appropriate, quality care and help keep your out-of-pocket costs down.

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

The Fund offers Participants (and covered Dependents) a Health Reimbursement Account (HRA) administered by the Fund Office on a self-insured basis. The HRA is designed to permit Participants to obtain reimbursement of Eligible Medical Expenses on a nontaxable basis. The HRA is intended to qualify as an integrated health reimbursement arrangement under §105 and §106 of the Internal Revenue Code of 1986, as amended, IRS Notice 2015-87 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective.

The Trustees establish and maintain HRA accounts for each Member, but do not create separate funds or otherwise segregate assets for this purpose. The HRA accounts so established are merely recordkeeping accounts with the purpose of keeping track of contributions and available reimbursement amounts.

Eligibility

Local 21 Member Participant. In order for a Local 21 Member Participant to obtain reimbursement of HRA reimbursable expenses, he/she must be eligible for and enrolled in the Plumbers and Steamfitters Local 21 Welfare Fund or Retiree Plan as of the date the expense(s) was incurred.

Dependents. In order for a Participant's Dependents to obtain reimbursement of HRA reimbursable expenses, the Dependent(s) must be eligible for and enrolled in the Plumbers and Steamfitters Local 21 Welfare Fund or Retiree Plan as of the date the expense(s) was incurred.

Traveler/Out-of-Area Union Member Participant and Dependents. In order for a non-Local 21 member (and his/her Eligible Dependents) to obtain reimbursement of HRA reimbursable expenses, he/she must be eligible for and enrolled in his/her home local health and welfare plan as of the date the expense(s) was incurred. The home local health and welfare plan must provide minimum value coverage under the law. Satisfactory proof of enrollment is required for claims to be payable, including but not limited to a Certificate of Coverage.

Please note that you may not access the HRA to reimburse for premiums/out-of-pocket costs associated with Marketplace or individual health insurance. If you are enrolled in a Marketplace health plan or other individual health insurance coverage, you are not eligible for this benefit and must opt out (as described below). Participants who do not opt out will NOT have access to the HRA.

Contributions to the HRA

Your HRA Account is funded solely by contributions from Contributing Employers and you cannot add monies to the account through a voluntary salary reduction. Your HRA account will not be credited unless and until contributions are actually received by the Fund from your Employer. A Participant may be reimbursed tax-free for Eligible Medical Expenses (see below for more information) up to the balance of his or her HRA account balance.

Crediting your HRA Account

Your HRA Account will be credited at the beginning of the first month following the month in which contributions are received on your behalf from Contributing Employers in the amount set forth in the collective bargaining agreement. If contributions are not received for any given month, the HRA Account will not be credited. HRA accounts do not accrue interest or any other income.

Debiting and Available Amount

Your account will be debited for any reimbursement of Eligible Medical Expenses incurred by you or your Eligible Dependents during the Plan Year along with any administrative fees (if applicable).

At any time, the available amount for reimbursement of Eligible Medical Expenses is the amount credited to your HRA account from Contributing Employers plus any carryover of an unused account balance from prior Plan Years minus any claims submitted for reimbursement.

Suspension of HRA Account

A Participant may elect to suspend his or her HRA account by submitting a written letter to the Fund Office before the beginning of that Plan Year. The Participant's suspension election will remain in effect for the entire Plan Year to which it applies, and the Participant may not modify or revoke the election during that Plan Year. The Participant will not receive reimbursements for any Eligible Medical Expenses incurred during the period to which the suspension election applies. If a Participant suspends his or her HRA account for a period of time, Eligible Medical Expenses incurred before the beginning of the suspension period may be reimbursed during the suspension period, subject to the claims procedures contained herein, so long as no suspension election was in effect for the date(s) on which such expenses were incurred.

Permanent Opt-Out of HRA Account

In lieu of a temporary suspension of your HRA Account, you may elect to permanently opt out of and waive future reimbursements from your HRA Account. If you make such an election, contributions received after the opt-out election takes effect that would normally be credited to your HRA account will be forfeited and you will not receive reimbursements for any medical care expenses incurred after the opt-out election takes effect. Eligible Medical Expenses incurred before the opt-out election takes effect, however, may be reimbursed, subject to the claims procedures contained herein, so long as no suspension election was in effect for the date(s) on which such expenses were incurred.

The opportunity to make a permanent opt-out election shall be offered to each Participant at least annually.

Eligible Medical Expenses

The HRA Plan provides eligible Participants with an HRA account to allow reimbursement for "Eligible Medical Expenses" (defined below) that are generally not reimbursed by the health plan

such as co-payments, co-insurance, deductibles and other expenses as described in this section. This section explains what constitutes an Eligible Medical Expense.

Eligible Medical Expenses, Generally. "Eligible Medical Expenses" means expenses incurred by you or your Eligible Dependents for medical care, as defined in Internal Revenue Codes §105 and §213(d) (including, for example, amounts for certain hospital bills, doctor bills, dental bills and prescription drugs), but shall not include expenses that are described at the end of this section under Exclusions. Eligible Medical Expenses also includes reimbursement for Retiree Self-Pay premiums, Retiree Medicare Part B and Part D premiums, COBRA premiums, or premiums for dental coverage paid on an after-tax basis.

Incurred. An Eligible Medical Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical expenses incurred before you first become an Eligible Participant are not Eligible Medical Expenses. However, an Eligible Medical Expense incurred during one Plan Year may be paid during a later Plan Year, provided that no more than two years have passed since the expense was incurred and you were an Eligible Participant at the time the expense was incurred.

Cannot Be Reimbursed or Reimbursable From Another Source. Eligible Medical Expenses can only be reimbursed to the extent that you or another person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through a health insurance plan, other insurance, or any other accident or health plan. If only a portion of an Eligible Medical Expense has been reimbursed elsewhere (e.g., because the other plan imposes copayment or deductible limitations), the HRA Plan can reimburse the remaining portion of such expense if it otherwise meets the definition of an Eligible Medical Expense.

Schedule of Eligible Medical Expenses. The following is a list of Eligible Medical Expenses for which you may receive reimbursement under the Plan. The list does not include all possible qualified medical expenses. For questions about whether a medical expense is a qualified medical expense, contact the Fund Office.

Eligible Medical Expenses for HRA Reimbursement	
• Abortion • Acupuncture • Alcoholism Treatment • Ambulance • Annual Physical Examination • Artificial Limb • Artificial Teeth • Bandages • Birth Control Pills • Body Scan • Braille Books and Magazines (limited to the part of the cost that is more than the cost of regular printed editions) • Breast Pumps and Supplies • Breast Reconstruction Surgery	• Lead-Based Paint Removal (to prevent a child who has or had lead poisoning from eating the paint) • Lodging (the cost of meals and lodging at a hospital or similar institution if the principal reason for being there is to receive medical care) • Long-Term Care Services and Insurance Premiums • Medicines (only with a prescription) • Nursing Home • Optometrist • Orthodontia (braces for your teeth) • Osteopath • Oxygen and Oxygen Equipment • Physical examination

• Car Modifications (limited to the part of the cost for hand controls and other special equipment installed in a car for the use of a person with a disability) • Chiropractor • Christian Science Practitioner • Coinsurance • Contact Lenses • Copayment Amounts • Crutches • Deductibles • Dental Treatment • Diagnostic Devices • Drug Addiction Treatment (inpatient treatment at a therapeutic center, including meals and lodging during treatment) • Eye Exam • Eyeglasses • Eye Surgery • Fertility Enhancement • Guide Dog or Other Service Animal • Hearing Aids • Home Care • Home Improvements (for special equipment installed in a home, or for improvements, if the main purpose is for medical care) • Hospital Services • Insulin • Insurance Premiums (COBRA, Medicare Part B & D, Dental) • Intellectually and Developmentally Disabled, Special Home for (does not include your home or the home of a relative) • Laboratory Fees	• Pregnancy Test Kit • Prosthesis • Psychiatric Care • Psychoanalysis • Psychologist • Special Education (when recommended by a doctor for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities) • Sterilization • Stop-Smoking Programs • Surgery (except those for unnecessary cosmetic surgery) • Telephone (equipment that lets a person who is deaf, hard of hearing or has a speech disability communicate over a regular telephone) • Television (equipment that displays the audio part of television programs as subtitles for persons with a hearing disability) • Therapy • Transplants (for medical care you receive because you are a donor or a possible donor) • Transportation (amounts paid for transportation primarily for, and essential to, medical care) • Vasectomy • Vitamins and Food Supplements (when prescribed by a physician) • Weight-Loss Program (if it is a treatment for a specific disease diagnosed by a physician) • Wheelchair • Wig (for the mental health of a person who has lost all of his or her hair from disease) • X-ray

Forfeiture of Accounts

An HRA account will be forfeited following six months of inactivity (i.e. no claims submissions for six months) after the date of termination of eligibility for Welfare Fund or Retiree Plan benefits. Any monies available from forfeited accounts will be applied to the Welfare Fund's administrative costs. However, should you return to Covered Employment and become eligible under the Welfare Fund and HRA Plan within 5 years of the date your account is forfeited, the unused balance that was forfeited will be restored when you regain eligibility.

Notwithstanding the above, the HRA account of an active Participant (and any Dependents) eligible for and enrolled in the Welfare Fund or Retiree (and any Dependents) eligible for and enrolled in (or who has opted-out of) the Retiree Plan, will not be forfeitable under the 6-month activity rule described above.

Any claims for reimbursement for Eligible Medical Expenses submitted by Dependents of a deceased active Participant or Retiree, will be covered up to the unused amount in the HRA account, subject to the eligibility and claims procedures contained herein.

Reimbursement Procedure

In order to obtain reimbursement from the HRA, you must fill out the appropriate HRA claim form and submit it along with required documentation to the Fund Office no later than two years following the date the Eligible Medical Expense was incurred. Required documentation includes but is not limited to Empire BCBS Explanation of Benefits for denied services.

All requests for reimbursement must include the following information:

- The person or persons on whose behalf Eligible Medical Expenses have been incurred;
- The description of service and date expenses incurred;
- The amount of the requested reimbursement; and
- A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such expenses has been exhausted.
- Written proof from an independent third party showing that the Eligible Medical Expenses have been incurred, the amounts of such expenses and proof of payment. Acceptable proof includes a copy of the Explanation of Benefits or a copy of the original claim form along with a receipt of payment. A statement or bill from a provider is not generally considered acceptable and will usually require additional documentation to constitute adequate proof of a claim.

For reimbursement claims that are denied, whether in whole or part, see the *Claims and Appeals Procedures* section of this booklet.

Health Reimbursement Arrangement Plan Exclusions

The following is a list of some items that are not qualified medical expenses for purposes of reimbursement by the HRA Plan. These expenses are not reimbursable even if they meet the definition of medical care under the Internal Revenue Code and are otherwise reimbursable pursuant to guidance issued by the Internal Revenue Service with respect to Health Reimbursement Accounts.

Note: The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the HRA program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

Notwithstanding the foregoing, an HRA account may reimburse COBRA premiums that a Participant, Spouse or Dependent pays on an after-tax basis under any other group health plan sponsored by an employer.

1. Health insurance premiums for individual or Marketplace policies or for any other group health plan (including a plan sponsored by an Employer) except for: (i) Retiree Part B and Part D insurance premiums; (ii) COBRA premiums; and (iii) Premiums for dental coverage paid on an after-tax basis.
2. Babysitting, childcare and nursing services for a normal, healthy baby.
3. Any expense allowed as a childcare credit for tax purposes.
4. Controlled substances (such as marijuana) that aren't legal under federal law, even if such substances are legalized by state law.
5. Cosmetic surgery, except cosmetic surgery necessary to 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. For purposes of HRA Plan exclusions, cosmetic surgery includes both surgical and non-surgical procedures.
6. Custodial care at home or in a nursing or assisted-living facility. Custodial care refers to nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around and using the bathroom. Custodial care is excluded even if recommended by a doctor.
7. Diaper service.
8. Any amounts which you are reimbursed for by a flexible spending account if you or your Spouse contributes part of your income or your Spouse's income to the flexible spending account on a pre-tax basis.
9. Fitness classes such as dance classes or swimming lessons if they are only for the improvement of general health, even if recommended by a doctor.
10. Funeral and burial expenses.
11. Health club dues to improve one's general health or for business, pleasure, recreation or other social purposes.
12. Contributions to health savings accounts, including Archer Medical Savings Accounts (MSA).
13. Illegal operations, treatments or controlled substances, whether rendered or prescribed by licensed or unlicensed practitioners.
14. Massage therapy.
15. Maternity clothes.
16. Prescribed medicines and drugs when illegally imported from another country, except that you can apply for reimbursement of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.
17. Non-prescription drugs, except for insulin. You can only apply for reimbursement of non-prescription (over-the-counter) drugs when prescribed by a doctor.
18. Nutritional supplements, vitamins, herbal supplements, natural remedies, etc. unless prescribed by a doctor.

19. Personal use items ordinarily used for personal, living or family purposes unless it is primarily used to prevent or alleviate a physical or mental defect or illness. For example, the costs of cosmetics, toiletries and toothpaste are excluded.

20. Teeth whitening.

21. Veterinary Fees except for a guide dog or other service animal.

22. Weight-loss program if the purpose of the weight-loss program is the improvement of appearance, general health or sense of well-being. Diet food and beverages are also excluded.

23. Any item not specifically referenced herein that does not constitute medical or dental care as defined under Internal Revenue Code §213(d).

SUPPLEMENTAL DISABILITY BENEFITS

The Plan pays a benefit for Disability absences during which you (the Member Participant) are prevented from working as a result of a non-occupational injury, illness, or disease. For the purpose of this benefit, "Disability" or "Disabled" means the inability of a Member Participant to perform the duties of his or her job with a Covered Employer as a result of non-occupational illness or injury for which you are receiving New York State Disability benefits. You must show proof that you are receiving New York State Disability benefits in order to receive Supplemental Disability Benefits.

Your benefit will commence immediately upon receipt of the necessary proof by the Fund Office and is payable for a maximum of 26 weeks during any one period of disability. The Disability absence must commence while coverage under the Plan is in force. The amount of your daily benefit is $20 per work day, up to five days per week (paid weekly), less applicable Medicare and FICA withholding.

If your most recent disability is related or due to the same cause(s) as your prior disability for which you have received benefit payments, the Fund will treat your current disability as part of the prior claim. The limit of 26 weeks will still apply. If the most recent disability is due to an unrelated injury or illness, and you have returned to Covered Employment for at least one (1) day, it would be a new disability claim and you would be subjected to all the Plan provisions of a new claim.

Supplemental Disability Benefits are payable on a weekly basis until the earliest occurrence of one or more of the following:

- The date you return to active work;
- The date you no longer have a qualified disability;
- The date you fail to comply with any applicable Fund policy or the failure to re-certify the Disability;
- The date you have received the maximum 26 weeks that is payable under the Plan;
- The date you perform services for an employer (including self-employment); or
- The date you die.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the Plumbers and Steamfitters Local 21 Welfare Fund. It also describes the procedures for you to follow if your claim is denied in whole or in part, or if any adverse determination is made with respect to your claim, and you wish to appeal the decision.

The procedures described in this section apply to claims filed and appeals related to the self-funded Medical Benefits, Prescription Drug Benefits, Employee Assistance Program, Vision Benefits, Supplemental Disability Benefits and Health Reimbursement Account. For the insured Accidental Death and Dismemberment and Life Insurance Benefits, refer to the official Certificates of Insurance coverage for details on claims and appeals.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated Participants and Eligible Dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is experimental or investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

All notices sent to claimants relating to internal claims and appeal review for health and supplemental disability benefits will contain a notice about the availability of Spanish language services. Assistance with filing a claim for internal review in Spanish is available by calling 1-800-662-5193. Notices relating to internal review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-662-5193.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or

determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Key Definitions and General Information

"Adverse Benefit Determination" means, for the purpose of the initial and appeal claims processes:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit;
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
- A rescission of coverage, whether or not there is an adverse effect on any particular health or supplemental disability benefit. An adverse benefit determination does not include rescissions of coverage with respect to life insurance or accidental death and dismemberment benefits.

"Appropriate Claims Administrator" means the companies/organizations and types of claims that each administers under the Plan as outlined in the chart below.

"Claim" means, for purposes of benefits covered by these procedures, a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this section) in accordance with the Plan's claims procedures.

"Days" means, for the purpose of the claim filing and appeal procedures outlined in this section, calendar days, not business days.

"Health Care Professional" means, for the purposes of the claims and appeals provisions, a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

"Insurer" means the insurance company that provides insured benefits under the Plan as outlined in the chart below.

See the chart titled *When you have questions about your benefits* at the beginning of this booklet for the contact information for the Appropriate Claims Administrators and Insurers. The Plan has delegated responsibility for Initial Claims Decisions and Appeals as follows:

INSURED BENEFITS: For claims administration and appeals under the insured benefits listed below, refer to the Participant Handbooks, Contracts and Certificate of coverages of the applicable insurance companies for details on claims and appeals.	
Benefit/Insurer/Applicable Claims Administrator	**Types of Claims Insured and Processed**
Accidental Death and Dismemberment (AD&D) and Life Insurance Benefits Mutual of Omaha	• AD&D Claims and Appeals • Life Insurance Claims and Appeals • Please note that claims should be sent to the Fund Office and will be forwarded to Mutual of Omaha once eligibility is verified
SELF-INSURED BENEFITS: The following are the companies/organizations that administer the self-insured benefits and are referred to as the Appropriate Claims Administrator. The types of claims each administers are outlined below.	
Benefit/Insurer/Applicable Claims Administrator	**Types of Claims Insured and Processed**
Medical Benefits Empire BlueCross BlueShield	• Pre-service, including Urgent care and Concurrent, Medical claims • Post-service Medical claims • Pre-Service and Post Service Appeals
Prescription Drug Benefits/Pharmacy Benefits Manager OptumRx	• Pre-service claims (drugs requiring prior approval) including Urgent care and Concurrent claims) as described in the Prescription Drug section • Post-service drugs if you fail to use your card to obtain a prescription or you fill it at a non-participating pharmacy • Pre-Service and Post Service Appeals
HRA Fund Office	• Post-service claims for reimbursement
Vision Benefits Fund Office	• Request Vision voucher • Post-service vision claims if you use an Out-of-Network provider
Vision Resources and Vision Network	• Network of Vision Providers
Supplemental Disability Benefits Fund Office	• Supplemental Disability Claims and Appeals

Types of Claims

Health benefit claims can be filed for medical, prescription drug, EAP, Health Reimbursement Arrangement (HRA) and vision benefits. There are four categories of health claims as described below:

Pre-Service Claim. A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. Pre-service claims include Urgent Care and Concurrent claims. Under this Plan, the services that require precertification (also called prior authorization) are described in the following sections of this document:

- **Medical Benefits –** see the *Medical Program* section of this Booklet for Preauthorization requirements that apply to these benefits
- **Prescriptions Drugs** – see the subsection, "*Utilization and Clinical Management Programs*" under the *Prescription Drug Benefits* section for details about which drugs require prior approval.
- **Vision Benefits –** see the *Vision Benefits* section for details about services for which a voucher is required prior to access.
- **EAP Benefits** – see *The Lower Hudson Valley Building and Construction Trades Employee Assistance Program (LHV-EAP)* section for details about program requirements and referrals.

Urgent Care Claim. An urgent care claim is any Pre-Service Claim for health care treatment that could:

- Seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function; or
- In the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

Concurrent Care Claim. A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment.

Post-Service Claim. A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Supplemental Disability Claims. A Supplemental Disability Claim is a request for supplemental non-occupational disability benefits where the Plan conditions payment on you receipt of New York State Disability Benefits.

Life and Accidental Death & Dismemberment Claims. A Life and Accidental Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant. A claim for an Accidental Death and Dismemberment Benefit may also be filed by a participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's claims processing procedures:

- Be written or electronically submitted (oral communication is acceptable only for urgent care claims),
- Be received by the Appropriate Claims Administrator as that term is defined in this section;
- Name a specific claimant including his/her date of birth and any ID number,
- Name a specific medical condition or symptom,
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted In-Network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan; or
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Authorized Representatives

An authorized representative, such as your Spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Claims Procedures

Claim Filing Deadline. Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Health Care Claims – Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible

(and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims.** Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

- **Urgent Care Claims.** In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

  If you improperly file an Urgent Care Claim, the Claims Administrator will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **Concurrent Claims.** If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section. A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

  If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claim.** Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part). The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Life Insurance and AD&D Insurance Claims (Non-Health Care Claim). You should file claims with the Fund Office and they will forward the claim to the Insurer. Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Insurer. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Insurer, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Supplemental Disability Claims (Non-Health Care Claim). Claims for Supplemental Disability Benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part). The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has 30 days to make a decision and notify you in writing (or electronically, as applicable).

Misdirected Post-Service Claims. If you mistakenly send a Post-Service claim to the Fund Office which you should have sent elsewhere (for example, if you send Post-Service claims for Empire PPO benefits to the Fund Office for processing), the Fund Office will immediately send the claim to the correct address.

For Information About Claims

If you have any questions about filing a claim, you can call the Fund Office directly at (914) 737-7220. See the "When you have Questions About your Benefits" section above for information about how to contact the Fund Office or the applicable Claims Administrator.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination. If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (for health claim – include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims - include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review for health benefit claims)
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- With respect to health and supplemental disability claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;
- Provide an explanation of the Plan's internal appeal (and external review for health claims) processes along with time limits and information about how to initiate an appeal and an external review;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol, standard or similar criteria, a statement will be provided that such rule, guideline, protocol, standard or similar criteria that was relied upon will provided to you free-of-charge upon request;
- If the denial was based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request; and
- For Urgent Care Claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification.
- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims. If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Request for Review of a Denied Claim (Appeal)

Health and Supplemental Disability Claim Appeals. If an initial health or Supplemental Disability claim is denied (in whole or in part) and you disagree the appropriate Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have one hundred eighty (180) calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this one hundred eighty (180) calendar day period. You should file your appeal with the applicable entity that acts as the fiduciary for each of the appeals as listed below.

Life Insurance and AD&D Benefits Appeals. If an initial life insurance and/or AD&D claim is denied and you disagree with the Insurer's decision, you or your authorized representative may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period.

Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review. See the "External Appeals" section later in this section.

Where to File an Appeal

Medical and Prescription Drug Claims Appeals. The Plan maintains a one-level internal appeal procedure for medical and prescription drugs as follows:

- ***Medical Appeals***. Empire breaks appeals into two (2) categories, Appeals and Grievances, which they define as follows:
  - An appeal is a request to review and change an Adverse Determination made when: (i) Empire's Medical Management Program (MMP) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if Empire denies a claim, wholly or partly, for services already rendered, based on their utilization review process.
  - A grievance is a verbal or written request for a review of an Adverse Determination concerning an administrative decision not related to medical necessity.

  To submit an appeal or grievance, call Member Services at the telephone number located on the back of your identification card, or write to the Empire at the address(es) listed on your ID card or the Explanation of Benefits (EOB). Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

- ***Prescription Drug Claim Appeals*.** To file an internal appeal for Prescription drug benefits (for pre-service, urgent, concurrent or post-service claims), you must submit a written statement to the Plan's Pharmacy Benefit Manager (PBM) at:

  OptumRx
  1600 McConnor Parkway
  Schaumburg, IL 60173-6801
  Telephone: (866) 863-1408

Appeal requests involving Urgent Care Claims may be made orally by calling the applicable Claims Administrator.

A voluntary level of appeal to the Board of Trustees is also available for post-service claims. If you are dissatisfied with the results of an internal appeal determination for a post-service claim, you may file a voluntary appeal with the Board of Trustees at the below address. For more information about voluntary appeals, please see section titled *Voluntary Appeals*.

You also have the right to file an External Appeal for certain types of claims. If you file an External Appeal before your file a Voluntary Appeal, you will forfeit your rights to file a Voluntary Appeal. For more information about the external appeals process and what claims are eligible, please see section titled *External Appeal of Medical and Prescription Drug Claims.*

Post-Service Vision, EAP, and HRA, Supplemental Disability Benefits, and Voluntary Appeal for Medical and Prescription Drug Benefits. To file an appeal for post-service claims for Vision, EAP, and HRA, Supplemental Disability Benefits, and Voluntary Appeal for Medical and Prescription Drug Benefits, you must submit a written statement to the Plan at the following address:

Board of Trustees
Plumbers and Steamfitters Local 21 Welfare Fund
1024 McKinley Street
Peekskill, NY 10566

Life Insurance and AD&D Insurance Claims (Non-Health Care Claims). To file an appeal for Life or Accidental Death and Dismemberment, contact the applicable Insurer.

Review Process for Medical, Disability, and Prescription Drug Claims

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments. As part of its internal appeals process, you will be provided with:

- The opportunity, upon request and without charge, for reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

- With respect to health and supplemental disability benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;
- A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- With respect to health and supplemental disability benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.
- A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Appropriate Claims Administrator will:
    - Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment, and
    - Is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
    - The Plan will provide, upon request the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

Pre-Service Medical, Prescription Drug and EAP Claims Appeals

- **Urgent Care Claims Appeals.** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of receipt of your (oral or written) request for appeal.

- **Concurrent Claims**. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- **Pre-Service Claims Appeals.** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received. No extension of this timeframe is permitted. However, it may extend the 30-day period due to special circumstances (e.g., the need to hold a hearing) if the claimant is notified of such extension within the initial 30-day period. The extension cannot extend beyond 60 days from the end of the initial 30-day determination period.

Post-Service Medical and Prescription Drug Claims Appeals. A written (or electronic, as applicable) notice regarding the Plan's determination on the appeal will be sent to you within 60 days from the date your written request for an appeal is received. No extension of the Plan's internal appeal review timeframe is permitted. However, it may extend the 60-day period due to special circumstances (e.g., the need to hold a hearing) if the claimant is notified of such extension within the initial 60-day period. The extension cannot extend beyond 60 days from the end of the initial 60-day determination period.

If you are still dissatisfied with the appeal determination for a post-service claim, you may request a Voluntary Review. You will have 60 calendar days from the date you received the notice of the final determination of the internal appeal to request a Voluntary Appeal by sending a written request to the Board of Trustees. Please see below sections entitled *Voluntary Appeals* for more information. You may file a request for an External Appeal in certain situations. See the section entitled, *External Appeal of Medical and Prescription Drug Claims*, for details on how to file a request for an External Appeal.

Supplemental Disability and Post-Service Vision and HRA Claims Appeals. The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Fund Manager/Board of Trustees will notify you

in writing of the benefit determination no later than 5 calendar days after the benefit determination is made.

Life Insurance and Accidental Death and Dismemberment Insurance Claims Appeals. A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Insurer.

Notice of Adverse Benefit Determination Upon Appeal

- A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes: the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- Reference the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the Plan's the external review process, along with any time limits and information regarding how to initiate the next level of review;
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

The Plan offers a Voluntary Appeal as described below. In addition, you may also file a request for an External Appeal (a description of that process follows the Voluntary Appeal section).

Voluntary Appeals

Should an adverse benefit determination be made upon review of your post-service claim by Empire BlueCross BlueShield or OptumRx, you will have an opportunity to choose a voluntary level of appeal before the Board of Trustees. Such claims must be filed within 60 from the date of the notice of the letter denying your internal appeal.

You should submit written comments, documents, medical records and other information relating to the claim for benefits. In administering the voluntary appeal, the Plan will obtain a written report summarizing the facts underlying the claim and prior denials from the appropriate Claims Administrator. .All voluntary appeals should be sent directly to the Board of Trustees at:

Board of Trustees
Plumbers and Steamfitters Local 21 Welfare Fund
1024 McKinley Street
Peekskill, NY 10566

This level of appeal is **completely voluntary**; it is **not** required by the Plan and is only available if you or your authorized representative request it. With regards to claims procedures pertaining to the voluntary appeal:

- The Plan will not assert a failure to exhaust administrative remedies where you or your authorized representative elect to pursue a claim in court rather than through the voluntary level of appeal;
- Where you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan Agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- Where claimant or authorized representative chooses to pursue an external appeal after completing the voluntary appeal, the Plan agrees that the timeframes for filing a timely external appeal will be tolled (suspended) during the period of the voluntary appeals process;
- The voluntary level of appeal is available only after you or your authorized representative have pursued the appropriate mandatory appeals process required by the Plan, as indicated previously in this section;
- Upon your request, the Plan will provide you or your authorized representative with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including specific information regarding the process for selecting a decision-maker and any circumstances that may affect the impartiality of the decision-maker.

Decisions on voluntary appeals will be made at the next regularly scheduled Board of Trustees meeting following receipt of request for review. However, if request for review is received within 30 days of the next regularly scheduled meeting, request for review will be considered at the second regularly scheduled meeting following receipt of the request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of request for review may be necessary. Once a decision on review of claim has been reached, notification of the decision will be sent as soon as possible, but no later than 5 days after the decision has been reached.

The Plan will not impose fees or costs on you or your authorized representative, should you or your authorized representative choose to invoke the voluntary appeals process. To request this level voluntary appeal, or if you have any questions, please contact the Fund Office.

External Review of Medical and Prescription Drug Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may be able to seek external review of your medical claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act. **These procedures**

pertain to Empire BlueCross BlueShield Medical and OptumRx Prescription Drug benefits only.

Claims Eligible for The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than Empire medical benefits.
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process. For claims administration and appeals under the insured benefits listed below, refer to the Member Handbooks, Contracts and Certificate of coverages of the applicable insurance companies for details on claims and appeals.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process. Note, however, that Voluntary Appeals are not a part of the Plan's internal appeals process, so an external review may be initiated without having filed a Voluntary Appeal. Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

Request for External Review of Standard (Non-Urgent) Claims. Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an adverse Appeal Benefit Determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

External appeals for the Medical Benefits are handled by Empire BlueCross BlueShield. All requests should be sent to them at:

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

External appeals for the Prescription Drug Benefits are handled by OptumRx. All requests should be sent to them at:

OptumRx
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Fax: fax: 1 (877) 239-4565

Preliminary Review of Standard Claims. Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

- You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and
- You have provided all of the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

External Review of Standard Claims. If the request is complete and eligible for an external review, the Plan will assign the request to an **Independent Review Organization (IRO)**. Empire has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims. Once the claim is assigned to an IRO, the following procedure will apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO

decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.
- The assigned IRO's decision notice will contain:
- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
- The date that the IRO received the request to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
- A statement that judicial review may be available to you; and
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

External Review of Expedited/Urgent Care Claims. You may request an expedited external review if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care,

continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

- External Review of Expedited Urgent Care Claims for Medical benefits, are handled by Empire BlueCross BlueShield. Please contact Empire BlueCross BlueShield at 1-800-553-9603 for the appropriate address.
- External Review of Expedited Urgent Care Claims for Prescription Drug benefits are handled by OptumRx. Please contact OptumRx at (866) 863-1408.

Preliminary Review for an Expedited/Urgent Care Claim. Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of Expedited Claim by an Independent Review Organization (IRO). Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide

coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Limitation on When a Law Suit May Be Filed

You may not start a lawsuit to obtain benefits until after you have submitted an appeal to the Board of Trustees requesting a review and a final decision has been reached on review. The law also permits you to pursue your remedies under ERISA Section 502(a) without exhausting these appeal procedures if the Plan has failed to follow them.

No legal action concerning a denial of benefits under the Plan may be commenced by a Participant, Beneficiary or other claimant (or an agent or representative acting on behalf of a Participant, Beneficiary or other claimant) against the Plan, the Fund, the Trustees, or any employee or representative of the Plan or Fund more than 180 days after the written decision from the Board of Trustees following an appeal. After the 180 day period, no legal action may be commenced against the Fund, Plan and/or the Board of Trustees.

All legal actions related to the Fund, Plan and/or Trustees may only be brought in the United States District Court for the Southern District of New York.

Participants and beneficiaries are not permitted to assign their right to sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which they may have against the Plan or its fiduciaries.

Judicial Deference

The Plan's decisions on review are to be accorded judicial deference to the extent that they are not arbitrary and capricious and do not constitute an abuse of discretion.

COORDINATION OF BENEFITS

These provisions apply to the self-insured Medical, Prescription Drug and Vision benefits described in this booklet.

Coordination of Benefits operates so that one of the plans (called the "primary plan") pays benefits first. The secondary plan may then pay the difference up to the allowable expenses. Any group plan that does not use these same rules or does not have any Coordination of Benefits rules will always pay first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Participant/dependent. The plan that covers you as Participant is primary, and the plan that covers you as a dependent is secondary. If you are insured as an active Participant under more than one health insurance plan, the plan that has provided coverage for you the longest will be the primary plan.

Dependent child/parents not divorced or separated. If a dependent child is covered under both parents' plans, the plan of the parent whose birthday is earlier in the year will pay first (this is often referred to as the "birthday rule").

Dependent child/parents divorced, separated or never married. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first.

If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If there is no court decree allocating responsibility for health care expenses, the plan of the parent with custody of the child pays benefits first. If the parent with custody remarries, then the primary plan will be that of the stepparent. The plan of the natural parent who does not have custody will pay third and the plan of the spouse of the non-custodial parent pays last.

Active/Laid-Off or Retired Participant: The plan that covers a person as any of the following pays first and the plan that covers the same person as a laid off or retired person, or the dependent of a laid off or retired person, pays second:

- An active participant of a Participating Employer (that is, a Journeyman, Steamfitter, Plumber or Apprentice of a Participating Employer who is neither laid-off nor retired);
- The dependent of an active participant of a Participating Employer;

- As a salaried participant of the Plumbers and Steamfitters Local Union No. 21, the Plumbers and Steamfitters Local Union No. 21 Pension Fund or the Plumbers and Steamfitters Local Union No. 21 Welfare Fund; or
- As the dependent of a salaried participant of the Plumbers and Steamfitters Local Union No. 21, the Plumbers and Steamfitters Local Union No. 21 Pension Fund or the Plumbers and Steamfitters Local Union No. 21 Welfare Fund
- Continuation coverage: If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as a participant, retiree, participant or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If a person is covered other than as a dependent (that is, as an participant, former participant, retiree, participant or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active participant under another plan, the order of benefits is determined by the first rather than by this rule.

Longer/Shorter Length of coverage: If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If the other coordinating plan determines benefits on the basis of Usual and Customary Charges, this Plan will use the Negotiated Amount as the allowable expense.
- When benefits are reduced by a primary plan because a covered Participant did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Coverage Under Medicare and This Plan When You Are Totally Disabled

If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second, provided you continue to pay the appropriate self-pay percentage to the Plumbers and Steamfitters Local 21 Welfare Fund.

Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease (ESRD)

If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of ESRD, this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Coverage Under Medicaid and This Plan

If an individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

Coverage Under TRICARE and This Plan

If a covered Dependent is covered by both this Plan and the TRICARE Program (formerly known as the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS) that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For a participant called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this plan is secondary for active participants 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.

Veterans Affairs/Military Medical Facility Services

If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are Usual and Customary.

Motor Vehicle coverage Required by Law

If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist

or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.

Workers' Compensation

This Plan does not provide benefits if expenses are covered by workers' compensation or occupational disease law or statutory programs. This applies even if the covered person does not claim benefits under the applicable law or after any applicable benefits are paid. A covered person must repay any benefits that may have been paid by the Plan because the covered person recovers the money in a lawsuit or other proceedings.

Medical coverage at Age 65: Medicare Participants May Retain or Cancel coverage Under This Plan

If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of age, disability or end-stage renal disease (ESRD), you may either retain or cancel your coverage under this Plan. If you and/or any of your Dependents are covered by both this Plan and by Medicare, as long as you remain actively employed, your medical expense coverage will continue to provide the same benefits and your contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation coverage. See the *COBRA Continuation Coverage* section of this booklet for further information about COBRA coverage. If any of your Dependents are covered by Medicare and you cancel that Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is yours, and yours alone. Neither this Plan nor your employer will provide any consideration, incentive or benefits to encourage you to cancel coverage under this Plan.

SUBROGATION & REPAYMENT OF MEDICAL BENEFITS

These provisions apply when the Plan pays benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery from any source.

Recovery. 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.

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, entity or party 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, attorney's fees, other expenses or costs.
- The Plan is not responsible for any attorney's 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.

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 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 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 judgement, settlement or underlying claim for damages or fully compensate you or make you whole.

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 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 Board of Trustees has sole discretion to interpret the terms of the Subrogation and Recovery provisions 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 these 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 these provisions.

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 also shall be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Plumbers and Steamfitters Local 21 Welfare Fund protect the confidentiality of your health information. Although the statement below describes how and when the Plan may use your protected health information (PHI), it is not intended to be, nor can it be construed as, the Plan's Notice of Privacy Practices. The Plan's Notice of Privacy Practices, which provides a complete description of your rights under HIPAA, was distributed to you upon enrollment and is available from the Plan's Privacy Officer at the Fund Office upon request. If you have questions about the privacy of your PHI, please contact the Privacy Officer. If you wish to file a complaint about a privacy issue, please contact the Privacy Officer at the Fund Office.

The Plan's Use and Disclosure of PHI: The Plan may use PHI without your authorization or consent to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan may use and disclose protected health information for purposes related to treatment, payment and health care operations, as defined below.

- ***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 health care providers.
- ***Payment*** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
  - Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing participant contributions for coverage;
  - Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), Coordination of Benefits, billing, collection activities and related health care data processing, and claims auditing; and
  - Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.
- ***Health Care Operations*** includes, but is not limited to:
  - Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, and patient safety activities;
  - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management,

contacting of health care providers and patients with information about treatment alternatives and related functions;

- Underwriting, enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers; and
- Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

- **When an Authorization Form is Needed:** Generally, the Plan will require you to sign a valid authorization form available from the Plan's Privacy Officer or Official before the Plan can use or disclose your PHI **other than** when you request your own PHI, a government agency requires it or the Plan uses it for treatment, payment or health care operations as described above. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization.

  The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a voluntary third level appeal or for other reasons related to the administration of the Plan. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

  1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
  2. Ensure that any agents, including subcontractors to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates and subcontractors to observe HIPAA privacy rules;
  3. Not use or disclose the information for employment-related actions and decisions;
  4. Not use or disclose the information in connection with any other benefit or participant benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
  5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the U.S. Department of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
11. In the event a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you in accordance with its privacy practices.

To ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following participants may be given access to use and disclose PHI:

- The Plan Administrator;
- Staff designated by the Plan Administrator;
- Business Associates under contract to the Plan including but not limited to Empire BlueCross BlueShield, OptumRx, LHV-EAP, Vision Resources and Vision Network.
- The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated by the Plan's Privacy Official.

In compliance with **HIPAA Security** regulations, the Plan Sponsor:

- Has implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;
- Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures;
- Ensures that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self funded medical/hospital benefits, self-funded prescription drug benefits, self-funded vision benefits, COBRA administration and Health Reimbursement Account (HRA) administration.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

PLAN CHANGE OR TERMINATION

Although it is not currently anticipated that the Trustees will terminate the Plan, the Trustees necessarily reserve the right to terminate it at an indefinite point in the future. The continuation of this Plan is also contingent upon the continuation of Employer contributions to the Fund.

If the Plan is terminated for any reason, the assets remaining in the Fund will be utilized to pay necessary administration costs and remaining benefits until such assets are depleted. If all assets are so expended, no further benefits would be provided by the Fund. Upon termination of this Plan, no individuals would have any further rights or vested interest in the Plan.

The Trustees also reserves the right to amend, modify, or terminate:

- the Plan;
- the types and amounts of benefits provided under the Plan; and/or
- the eligibility of individuals to receive benefits under this Plan, even if extended eligibility has already been accumulated.

Furthermore, the benefits provided by this Plan are not guaranteed, are not vested upon retirement, and are not deferred income. Additionally, the benefits provided by this Plan are subject to modification or termination by the Trustees, even if such action is not financially necessary. The Trustees must approve any Plan amendment and its effective date, and any Plan amendment must be in writing.

No individual has a vested right or a contractual interest in the benefits provided under this Plan. The provision of benefits to individuals under this Plan will be reviewed periodically by the Trustees.

Important Note

Your eligibility or your right to benefits under the Plan should not be interpreted as a guarantee of employment. Participation in the Plan does not limit or otherwise affect your rights, or those of your employer, under any applicable collective bargaining agreement.

OTHER IMPORTANT PLAN INFORMATION

The following information will help you properly identify your Plan if you have any questions about your benefits. It also provides other important information about your benefits.

Official Name of Plan

Plumbers and Steamfitters Local 21 Welfare Fund

Name and Address of Plan Sponsor

Board of Trustees
Plumbers and Steamfitters Local 21 Welfare Fund
1024 McKinley Street
Peekskill, NY 10566

Plan Administrator

Brendan Foley
Plumbers and Steamfitters Local 21 Welfare Fund
1024 McKinley Street
Peekskill, NY 10566

Employer Identification Number (EIN)

13-4017983

Plan Number

501

Type of Plan

This Plan is a participant Welfare Benefits Plan including medical, hospital, prescription drug, vision, employee assistance program, health reimbursement account, life insurance, and accidental death and dismemberment benefits.

Type of Administration

Plumbers and Steamfitters Local 21 Welfare Fund self-insures and self-administers the vision benefits and the Health Reimbursement Account (HRA).

OptumRx serves as a third-party administrator for the self-insured prescription drug benefits, and can be contacted at the following address:

OptumRx
2300 Main Street
Irvine, CA 92614

Empire BlueCross BlueShield serves as a third-party administrator for the self-insured hospital and medical benefits and can be contacted at the following address:

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

Lower Hudson Valley Employee Assistance Program serves as a third-party administrator for the self-insured employee assistance, mental health and substance abuse disorder benefits, and can be contacted at the following address:

Lower Hudson Valley Employee Assistance Program
3505 Hill Blvd - Suite A
Yorktown Hts., New York 10598

The life insurance and accidental death and dismemberment benefits are insured and administered by Mutual of Omaha and can be contacted at the following address:

Mutual of Omaha Companion Life Insurance Company
Group Life Claims
3316 Farnam Street
Omaha, Nebraska 68175-5102

Agent for Service of Legal Process

For disputes arising under the Plan, service of legal process may be made upon:

Board of Trustees
Plumbers and Steamfitters Local 21 Welfare Fund
1024 McKinley Street
Peekskill, NY 10566

Service may also be made upon any individual Trustee or the Plan Administrator.

For disputes arising under the portions of the Plan insured by Mutual of Omaha, service may be made upon that organization at one of its local offices or upon the supervisory official of the insurance department in the state in which you reside.

Funding Medium and Benefits

Benefits are provided from the assets contributed by Employers pursuant to Collective Bargaining Agreement(s) and by Participants and held in trust by the Board of Trustees pursuant to the

Indenture Trust. Copies of the collective bargaining agreements related to the Fund are available for inspection. Participants or beneficiaries can request, in writing, a copy of these agreements.

Participating Employers

All contributions to the Plan are made by employers in accordance with Collective Bargaining Agreements and participation agreements between the Plumbers and Steamfitters Local 21 and employers in the industry. The Collective Bargaining and participation agreements require contributions to the Plan at a fixed rate per hour worked. Upon written request to the Fund Administrator, you may receive information as to whether a particular employer is a Contributing Employer, and, if so, the employer's address.

Plan's Fiscal Year (Plan Year)

Financial records are kept on a 12-month basis. The Plan Year begins on July 1 and ends on the following June 30.

Discretionary Authority of the Trustees and Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, 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, and to decide any fact related to eligibility for and entitlement to Plan benefits. Any interpretation or determination under such discretionary authority will be given full force and effect, and should receive judicial deference, unless it can be shown that the interpretation or determination was arbitrary and capricious.

No Liability for Practice of Medicine or Dentistry

The Plan, the Board of Trustees, or any of their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you (or your covered Dependents) by any health care provider. Neither the Plan, the Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you (or your covered Dependents) by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Effective Date of this Plan

July 13, 1956

YOUR RIGHTS UNDER ERISA

As a Participant in the Plumbers and Steamfitters Local 21 Welfare Fund, you are entitled to certain rights and protections under the Participant Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About your Plan and Benefits

- Examine, without charge, at the Fund Office and at all other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Fund Office, copies of documents governing operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (SPD). The Fund Office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Office is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan coverage

- 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 Summary Plan Description (SPD) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

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

Enforce your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 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. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area Office of the Participant Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Participant Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington DC, 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Participant Benefits Security Administration.

DEFINITIONS

The following terms generally apply throughout the entire Summary Plan Description (this booklet):

"Benefit Quarter" means the calendar quarter for which a Participant is eligible for Fund benefits as a result of meeting the minimum hours requirements in a Work Period.

"Calendar Year" A period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

"Child" includes a natural child, stepchild and adopted child including a proposed adopted child during any waiting period prior to the finalization of the child's adoption. 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.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

"Code" means the Internal Revenue Code of 1986 as amended.

"Contract Year" is the 12 consecutive month period of the policy or administrative services contract under which Plan benefits are provided. The Contract Year is not the same as the Plan Year. See also the definitions of Calendar Year and Plan Year.

"Coordination of Benefits (COB)" means the rules and procedures applicable to determination of how medical and dental benefits are payable when a person is covered by two or more such care plans.

"covered Employment" means an Participant who is working for a covered Employer who is obligated under the terms of a Collective Bargaining Agreement to contribute to the Welfare Fund on his or her behalf.

"Dependent Child(ren)" means your children (married or unmarried) until the end of the month they reach the age of 26. "Child" includes a natural child, stepchild and adopted child including a proposed adopted child during any waiting period prior to the finalization of the child's adoption, who meet the eligibility requirements detailed in the Eligibility section.

"Dependent" or **"Eligible Dependents"** or **"covered Dependent"** include your Spouse and/or Dependent Child who meet the eligibility requirements detailed in the Eligibility section.

"Employer" or **"covered Employer"** or **"Participating Employer"** or **"Contributing Employer"** means an employer signatory to a collective bargaining agreement, or any other agreement with the union or Trust, requiring contributions to the Trust for work in covered Employment.

"Exclusions" means services or supplies that the Plan does not pay for or cover.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Fund Assets" means the assets of the Fund and consists of (1) the sums of money that have been or will be paid or which are due and owing to the Fund by the Employers as required by Collective Bargaining Agreements; (2) all investments made therewith, the proceeds thereof and the income there from; (3) all other contributions and payments to or due and owing to the Trustees from any source to the extent permitted by law; and (4) supplies, property and other assets used by the Trustees in the administration of the Fund.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Member" or **"Member Participant"** means, unless specifically indicated otherwise, a person employed by an Employer who is a signatory to a collective bargaining agreement, or other agreement with the Union or Trust requiring contributions to the Trust for work in covered Employment.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Participant" or **"covered Participant"** or **"Eligible Participants"** means any Participant or Retiree (as that term is defined in this Plan), who have met all the eligibility requirements of the Plan and is actually covered by the Plan.

"Plan" or **"This Plan"** means the programs, benefits and provisions described in this document and the applicable appendices.

"Plan Document" means this document along with any appendices.

"Plan Year" means the twelve-month period from July 1 to June 30 designated to be the Plan Year. The Contract Year is not the same as the Plan Year. See also the definitions of Calendar Year and Contract Year.

"Qualified Medical Child Support Order (QMCSO)" means a support order of a state or administrative agency that usually results from a divorce or legal separation, complies with requirements of federal law, that may require an participant to provide health care coverage for a Dependent Child, and requires that benefits payable on account of that Dependent Child be paid directly to the health care provider who rendered the services or to the custodial parent of the Dependent Child.

"Retiree" means a Participant who is eligible to receive benefits under this Plan on the date his/her pension payments commence.

"Spouse" means the person to whom the Member Participant is lawfully married.

"Work Period" means the six-month or twelve-month period used to determine eligibility under the Plan.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

"You, your" when used in this document, these words refer to the active Participant or Member who is covered by the Plan. They do not refer to any Dependent of the Participant.

The following terms apply specifically to your Medical and Prescription Drug Benefits:

"Acute" means the onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

"Allowed Amount" means the maximum amount on which the Fund payment is based for Covered Services. The Allowed Amount is 150% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type, unadjusted for geographic locality. See the Cost-Sharing Expenses and Allowed Amount section of this Booklet for a description of how Empire calculates the Allowed Amount.

"Ambulatory Surgical Center" means a Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

"Balance Billing" means when a Non-Participating Provider bills you for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill you for Covered Services.

"Benefit Period" means the length of time the Fund will cover benefits for Covered Services. The Fund operates on a Calendar Year benefits period. If your coverage ends before the end of the year, then your Benefit Period also ends.

"Applicable Claims Administrator" means the organization the Fund has chosen to administer components of its health benefits. Empire BlueCross BlueShield is the Claims Administrator for Medical and Hospital Benefits. OptumRx is the Claims Administrator (and "pharmacy benefits manager" or PBM) for Prescription Drugs. LHV-EAP is the Claims Administrator for EAP benefits. The Fund Office is the Claims Administrator for the HRA and vision benefits. Mutual of Omaha is the claims administrator for life and AD&D insurance benefits.

"Coinsurance" means your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that you are required to pay to a Provider. The amount can vary by the type of covered Service.

"Copayment" means a fixed amount you pay directly to a Provider for a Covered Service when you receive the service. The amount can vary by the type of Covered Service.

"Cost-Sharing" means amounts you must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

"cover" or **"covered"** or **"Covered Services"** means the Medically Necessary services paid for, arranged, or authorized for you by the Plan under the terms and conditions of this Booklet.

"Deductible" means the amount you owe before the Plan begins to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services.

"Durable Medical Equipment (DME)" means equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

"Emergency Condition" means a medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

"**Emergency Department Care"** means emergency Services provided by a Hospital emergency department.

"**Emergency Services"** means a medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such 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. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

"Facility" means a Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If you receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

"Grievance" means a complaint that you communicate to Empire that does not involve a Utilization Review determination.

"Health Care Professional" means 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 analysis; 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 Plan.

"Home Health Agency" means an organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

"Hospice Care" means care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

"Hospital" means a short term, acute, general Hospital, which:

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

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

"Hospitalization" means care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

"Hospital Outpatient Care" means care in a Hospital that usually doesn't require an overnight stay.

"Martial/Married" means and refers to a legal relationship between two individuals of any gender who are lawfully married pursuant to an official marriage license or similar document issued by any state (without regard to the law of the state in which the individuals live), but NOT including civil unions, domestic partnerships or any other status unless such status is fully equivalent to marriage under the laws of the issuing state.

"Medically Necessary" See the *How your coverage Works* section of this Booklet for the definition.

"Medicare" means Title XVIII of the Social Security Act, as amended.

"Non-Participating Provider" or **"Out-of-Network Provider"** means a Provider who does not have an agreement or contract with Empire or another BlueCross and/or BlueShield plan to provide services to you. You will usually pay more to see a Non-Participating Provider.

"Out-of-Pocket Limit" means the most you pay during a Benefit Period in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services. This limit never includes your Fee, Balance Billing charges or the cost of health care services the Plan does not cover.

"Participating Provider" or **"In-Network Provider**" means a Provider who has a contract with Empire or another BlueCross and/or BlueShield plan to provide services to you. A list of Participating Providers and their locations is available on Empire's website at *www.empireblue.com*. You can also request that a directory be mailed to you free of charge by contacting Empire at 1-800-342-9816. The list will be revised from time to time by Empire.

"Physician" or **"Physician Services"** means health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

"Plan Assets" means the assets of the Fund consist of (1) the sums of money that have been or will be paid or which are due and owing to the Fund by the Employers as required by Collective Bargaining Agreements, (2) all investments made therewith, the proceeds thereof and the income there from, (3) all other contributions and payments to or due and owing to the Trustees from any source to the extent permitted by law and (4) supplies, property and other assets used by the Trustees in the administration of the Fund.

"Preauthorization" means a decision by Empire prior to your receipt of a covered Service, procedure, treatment plan, device, or Prescription Drug that the covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. Covered Services which require Preauthorization are listed in the Preauthorization section of this booklet.

"Prescription Drugs" means a medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

"Primary Care Physician (PCP)" means a participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for you.

"Provider" means a Physician, Health Care Professional or Facility licensed, registered, certified or accredited 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 Booklet that is licensed, registered, certified or accredited as required by law.

"Rehabilitation Services" means health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

"Schedule of Benefits" means the sections of this booklet that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits and other limits on Covered Services.

"Service Area" means the geographical area, designated by Empire and approved by the State of New York in which Empire provides coverage. Our Service Area consists of the following 28 counties in eastern New York State: 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 and Westchester.

"Skilled Nursing Facility" means an institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Empire to meet the standards of any of these authorities.

"Specialist" means a Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

"UCR (Usual, Customary and Reasonable)" means the cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The Plan's Allowed Amount is not based on or intended to be reflective of fees that are or may be described as usual, customary and reasonable (UCR).

"Urgent Care" means medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

"Urgent Care Center" means a licensed Facility (other than a Hospital) that provides Urgent Care.

"Utilization Review" means the review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

A FINAL WORD

This booklet describes the major provisions of the Plumbers and Steamfitters Local 21 Welfare Fund. It contains Summary Plan Descriptions (SPD) as defined by the Participant Retirement Income Security Act of 1974 (ERISA). The benefits described are subject to the terms, conditions, limitations and exclusions of any applicable contract entered into by the Fund. If there is any difference between what this booklet describes and any applicable Plan documents, the language in the Plan documents will prevail. Any oral or written representations by a Fund participant or agent, or any benefit estimates that you may receive, cannot override, reverse or supplement the provisions of the applicable Plan documents.

This booklet replaces any prior materials describing the Plumbers and Steamfitters Local 21 Welfare Fund. Currently, the Plumbers and Steamfitters Local 21 Welfare Fund expects to continue this program indefinitely, but reserves the right to change, reduce or eliminate the benefits described in this booklet or any other participant benefit program in whole or in part at any time.

The provisions in this booklet are subject to the rules and regulations of the Fund adopted by the Board of Trustees from time to time, and by the Trust Indenture which established the Fund and governs its operations.

The Board of Trustees shall be the sole and final judge of the standard of proof required in any case, the application and interpretation of the provisions in this booklet and all applicable Plan documents, and the entitlement to or amount of benefits. Only the Board of Trustees, in its sole discretion, may decide, by rules uniformly applicable to all persons similarly situated, whether and to what extent benefits will be paid. The Board of Trustees reserves the right to change or eliminate the rules or benefits described in this booklet, in the exercise of its sole discretion. Participation in this Fund does not constitute a contract of employment between you and a participating employer.