LOCAL 807

LABOR - MANAGEMENT

HEALTH FUND

SUMMARY PLAN DESCRIPTION

2016

Local 807 Labor-Management Benefit Funds

32-43 49th Street

Long Island City, New York 11103

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GRANDFATHERED HEALTH PLAN

This group health plan or health insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 718-274-5353. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or **www.dol.gov/ebsa/healthreform.gov**. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**.

Introduction

The Local 807 Labor-Management Health Fund (the "Fund" or the "Plan") is pleased to provide you and your family with broad protection to help meet the costs of Sickness and Injury as well as Prescription Drug, Dental, and Vision Expenses.

This Summary Plan Description ("SPD") includes comprehensive information about your benefits. Please keep this SPD in a safe place. It is intended to help you understand the benefits that are available to you and your Covered Dependents.

On occasion, a doctor or a Hospital may recommend a course of treatment that is not considered to be Medically Necessary or otherwise appropriate by the Fund, or by one or more of the Fund's medical experts. In cases like that, the Trustees have the obligation and the power to make any final decision about whether the Fund will reimburse any expense that may be incurred by a Covered Person. In making a coverage determination, the Trustees will consider any relevant information that may be made available to them by the Covered Person or the Covered Person's representative and will rely on various experts who have been hired to assist the Trustees and the Fund employees in administering the Fund. The Trustees' decision to cover or to not cover any expense will be final and binding on the Fund and the Covered Person.

If you have any questions about the coverage of any medical or Hospital expense, please call the Fund Office. In some cases, your question may have to be reviewed by the Trustees. Only the written answers you receive from the Trustees are binding and final. Answers from Fund employees are only opinions based upon the employee's familiarity with the Fund's past practices and the terms of this SPD and do not bind the Fund to reimburse any particular expense.

You will notice that certain words are capitalized throughout the text of this SPD. These words are defined terms and have specific meaning within this document.

This SPD replaces any prior SPDs or certificates you may have received.

General Information

As explained above, the Trustees make all decisions regarding the Fund. However, you may occasionally come into contact with one or more of the companies hired by the Trustees to assist in the administration of the Fund's benefits.

Empire BlueCross BlueShield provides Hospitalization coverage for Covered Persons. Initial decisions about any issue relating to your stay in a Hospital, or the course of treatment that will be reimbursed by the Fund, are made by Medical Management in accordance with their established standards for care.

MagnaCare is a network of doctors and laboratories that provides medical services to Covered Persons.

MedReview Medical Management is the third-party provider responsible for the Fund's precertification for Hospital-related services.

Other Third-Party Suppliers provide dental, vision, prescription drug and temporary Disability benefits. Those suppliers are all listed in the Definitions section as Third-Party Suppliers. If you have any question about the role of any of these Third-Party Suppliers, or about the coverage of any expense, please call the Fund Office at 718-274-5353.

Eligibility and Effective Dates of Coverage

Initial Eligibility

Active Employees' Eligibility

You first become eligible for benefits on the first day of the Health Fund Coverage Quarter following completion of at least 250 hours of work in Covered Employment in the immediately preceding Eligibility Quarter. See the chart below, which shows the Eligibility Quarters and the corresponding Health Fund Coverage Quarters.

If you have at least 250 Contribution Hours during Fund Eligibility Quarter:	You will then become eligible for the entire Health Fund Coverage Quarter on the 1st of the month of the Health Fund Coverage Quarter:
May-June-July	September-October-November
August-September-October	December-January-February
November-December-January	March-April-May
February-March-April	June-July-August

You will be credited for days worked only after your Employer has submitted the required reports and contributions for each period. Any claims you may have while your Employer is delinquent will be suspended until the Employer makes the payments that are required under the terms of the Collective Bargaining Agreement and the Plan's Trust Agreement.

Seasonal Employees – Look-Back Rule

If you are engaged in irregular or seasonal Covered Employment and, because of the nature of the work, are unable to accrue the required 250 hours in any given Eligibility Quarter, you may still be eligible for benefits. Under a special "look-back rule," the Trustees may determine that you are eligible for benefits if you have accumulated at least 1,000 hours of Covered Employment during the current and the three immediately preceding Eligibility Quarters. If you are in this situation, please contact the Fund Office for a determination of your eligibility. The Trustees are the sole judges of your eligibility. This 1,000-hour look-back is not applicable to employees who have terminated Covered Employment or who are employed by an Employer that has ceased to be a Contributing Employer. Any individual who receives coverage under this look-back rule will not be entitled to two consecutive Eligibility Quarters under this look-back rule.

Disability Credit

If an employee becomes disabled, and is paid benefits under the Worker's Compensation Law or other state-required Disability insurance, the employee will continue to have working days credited towards eligibility for coverage provided that:

- The employee's Employer is required to contribute to the Fund pursuant to a Collective Bargaining Agreement with Local 807 and is not delinquent;
- The employee was eligible for active benefits during any four consecutive quarters in the previous six quarters preceding the quarter in which the employee became disabled; and
- The employee's Disability lasts 29 days or longer.

Credit is allowed on the basis of 20 hours for each week of Total Disability. If the employee does not need the credit to meet the eligibility requirement in the Fund Eligibility Quarter in which the employee became disabled, the credit will be carried over and applied in the subsequent Fund Eligibility Quarter. For all individuals receiving Worker's Compensation, credit will be limited to four quarters while on Worker's Compensation. For all individuals who are disabled but not receiving Worker's Compensation, credit will be limited to two quarters.

Employees receiving Worker's Compensation benefits must notify the Fund Office to qualify for this credit.

Continuing Coverage

Once you have become eligible for benefits under the Fund, you will continue to be eligible for active benefits as long as you work at least 250 hours in Covered Employment in each subsequent Fund Coverage Quarter.

Your Dependents continue to be eligible for benefits as long as you are eligible and they meet the definition of Dependent.

Dependent Eligibility

Your Eligible Dependents include your:

Spouse

Your Spouse, but only if you were legally married under the laws of the State in which the marriage took place.

Children Under Age 26

Your eligible child(ren) include any of your children (whether married or unmarried) from the moment of birth to the end of the month in which the child turns age 26.

A child is a Dependent Child if the child is:

1. A biological child of yours (proof of relationship and age will be required);
2. A legally adopted child (proof of relationship and age will be required);
3. A child legally placed with you for adoption. Placed for adoption means the assumption and retention by you of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates (as will coverage for benefits) upon the termination of such legal obligation;
4. A stepchild who is the biological child of your present Spouse; or
5. A child who is permanently residing with you or your Spouse pursuant to an Order issued by a court of competent jurisdiction awarding you or your Spouse permanent and exclusive custody.

A Covered Person must, upon request, file a copy of his or her Internal Revenue Service Form 1040 showing that the child for whom you have guardianship has been declared by you a Dependent for federal income tax purposes. The Trustees may decline coverage of any child if the Trustees determine in their sole discretion that a custody arrangement was, either at its inception or at any time thereafter, merely a device or scheme designed for the purpose of obtaining medical coverage for the child.

The Fund may, from time to time, request the Participant and/or the Participant's Spouse having custody of the child to execute an affidavit or other statement confirming that the criteria set forth above continue to be met. The Trustees may condition continued coverage of the child upon execution of its affidavit/statement.

Coverage terminates at the end of the month in which the Dependent Child attains age 26.

The Plan does not cover foster children or those children in temporary custody. A spouse or child of a Dependent Child is not eligible for coverage under the Plan.

Ineligible Dependents

In no event will any of the following persons be eligible for coverage as a Dependent:

1. A former Spouse if an Order or Decree of annulment or divorce or legal separation has been entered by any Court of competent jurisdiction;
2. A Spouse who is on active duty in military service; or
3. A person who is eligible to be a Covered Person in the Fund in his or her own name and right.

Enrollment

Initial Enrollment

When you first become eligible for benefits under the Plan, you must complete an Enrollment form for yourself and any Dependents who will be covered by the Plan, including your spouse and any Dependent Children. In addition, if you acquire a new Dependent after you are initially eligible for benefits, you must enroll them. When you first enroll or add a new Dependent for coverage, you must provide the Fund Office with proof of Dependent status. The Fund Office will accept a certified copy of any of the following documents as proof of Dependent status:

- **Spouse/Marriage:** Marriage certificate.
- **Dependent Biological Child:** Birth certificate.
- **Stepchild:** The child's birth certificate and the marriage certificate between the child's parent and the Eligible Employee.
- **Adoption or Placement for Adoption:** court order paper signed by the judge showing that the Eligible Employee has adopted or intends to adopt the child and a copy of the certified birth certificate.
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically handicapped and is incapable of self-sustaining employment as a result of that handicap and chiefly dependent on you and/or your spouse for support and maintenance.

In order to complete enrollment, you must also:

- Provide a copy of your Social Security card and a copy of the Social Security card for each Dependent.
- Inform the Fund Office about your Dependents' employment and availability of other coverage.

There is no option to decline (opt-out of) Hospital, Medical or prescription drug coverage provided by this Plan. However, in accordance with Health Reform regulations, you do have the option to decline the Plan's dental and/or vision benefits. If you wish to decline dental and/or vision benefits, contact the Fund Office. If you decline dental and/or vision benefits, you may re-enroll for such coverage at any time by contacting the Fund Office. Changes to your enrollment in dental and/or vision benefits will be effective the first of the month following the month in which you re-elected coverage.

Special Enrollment and Requesting Enrollment

You may request enrollment in the Plan at any time. Specifically, you may request enrollment in this Plan:

- When you are first eligible for benefits and any time thereafter;
- When you have a new Dependent as a result of marriage, birth, adoption or placement for adoption;
- If you or your Dependent(s) lose eligibility for other health insurance or group health plan coverage (or if the Employer stops contributing toward your or your Dependents' other coverage); or
- If you (or your Eligible Dependents): (i) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage; or (ii) become eligible for a premium assistance program through Medicaid or CHIP.

There is no deadline for enrolling yourself or your Dependents in this Plan. However, coverage is not effective until the Fund receives your completed Enrollment Form (and the applicable proof of Dependent status). Once the Fund Office receives your completed Enrollment Form, coverage will be effective retroactive to the effective date of coverage (as described below). If proper enrollment has not been completed, claims will not be able to be considered for payment until such enrollment has been completed and submitted to the Fund Office. If you file claims and have not properly enrolled, your claims will be rejected and have to be re-submitted after you complete the enrollment process. Keep in mind that no claims will be paid if they are submitted (or re-submitted) after the deadlines for claims consideration (see the Claims Procedures section at the end of this document for those deadlines).

Effective Date of Coverage for Covered Persons

Eligible Employees

Coverage is effective on the first day of the first month of the Fund Coverage Quarter following the Fund Eligibility Quarter in which you meet the eligibility requirement.

Dependents

Dependents who are eligible and enrolled concurrently with you will be covered effective on the same day as you. Other Dependents will be covered once they become eligible and enrolled.

Newborn/Adopted Children

A child born to you (or an adopted newborn) after you have already been enrolled as a Covered Person will be covered from the moment of birth.

A child adopted by you or placed for adoption with you after you have already been enrolled as a Covered Person will be covered from the date the child is placed in your custody for the purpose of legal adoption.

Termination of Coverage

Except in the case of special circumstances described below, your coverage under the Fund will terminate on the earliest of the following:

1. At midnight of the last day of the last month of a Fund Coverage Quarter following any Eligibility Quarter in which you fail to work at least 250 hours in Covered Employment; or
2. Upon the termination of the Fund; or
3. The date on which your Employer or former Employer's Collective Bargaining Agreement expires and no new Collective Bargaining Agreement requiring contributions by your Employer to the Health Fund is negotiated.

Your coverage may be terminated retroactively (rescinded) in cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30-day notice) or due to the non-payment of premiums (including COBRA premiums).

Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a Dependent, or the existence of or eligibility for other coverage when you enroll a Dependent, add a Dependent, or complete the Enrollment Form constitutes intentional misrepresentation of material fact to the Plan.

Termination of Dependent Coverage

Your Dependent's coverage under the Fund will terminate upon the earliest of:

- The termination of the Fund;
- The termination of your coverage;
- Coverage ends for your Spouse on the date you and your Spouse are divorced or legally separated or your Spouse enters the armed forces of any country; or
- Coverage ends for your Dependent Child the end of the month in which your Covered Dependent Child ceases to meet the Fund's definition of Dependent Child unless coverage is extended under the Extension of Coverage for Handicapped Dependent Children.

Extension of Coverage for Handicapped Dependent Children

If an already Covered Dependent Child attains an age which would otherwise terminate his or her status as a "Dependent," and if, on the day immediately prior to the attainment of such age, the child was incapable of self-sustaining employment by reason of mental or physical handicap or any other Disability which commenced prior to the attainment of such age, then such child will continue to qualify coverage as a Dependent for so long as the child lives in your household and is fully dependent on you for support and maintenance.

You must, within 31 days following the child's attainment of such age, submit to the Fund Office sufficient medical information to prove, to the Trustees' satisfaction and in their discretion, the child's incapacity. You may be required to provide evidence of continuing mental or physical handicap from time to time, but not more frequently than once a year, after the second anniversary of the child's attainment of such age.

Notification Requirements

You, your Spouse or any of your Dependent Children must notify the Plan, preferably within 30 days, but no later than 60 days after:

1. The date your Spouse ceases to meet the Plan's definition of Spouse;
2. The date your Dependent Child ceases to meet the Plan's definition of Dependent Child; or
3. The date your Spouse or Dependent Child becomes employed, becomes eligible for, or enrolls in, other employer-sponsored coverage.

Loss of coverage may qualify a person for coverage under the Continuation of Coverage option known as COBRA. COBRA coverage is described later in this SPD and can be found in the Table of Contents.

If you fail to provide notice to the Plan of an event warranting termination of coverage and the Fund pays benefits for you or a Dependent after the termination date, and you and/or your Dependent have not elected COBRA continuation coverage, you will be responsible for reimbursing the Plan for any claims that are paid. Please note that regardless of when you give notice, coverage will be terminated as of the date the Dependent ceased to meet the definition of Dependent.

If Both You and Your Spouse are Eligible Employees

If you and your Spouse are both Eligible Employees and are covered as Eligible Employees under the Fund and one of you loses coverage upon terminating employment, the person losing coverage and any of your eligible and enrolled Dependents will be immediately enrolled under the remaining Eligible Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which you were entitled while enrolled as the Eligible Employee or the Dependent of the terminated Eligible Employee.

Qualified Medical Child Support Orders (QMCSOs)

If you are divorced or legally separated, your Dependent Child(ren) may continue to be covered for so long as they meet the definition of a Dependent Child.

According to federal law, you might be requested to enroll your Dependent Child(ren) in the Plan due to a Medical Child Support Order (MCSO) or a National Medical Support Order (NMSO) that is a Qualified Medical Child Support Order (QMCSO).

Benefits will be provided to natural Dependent Children and Dependent Children placed with a Participant for adoption if and as required by any QMCSO in accordance with ERISA §609(c). No coverage will be provided for any Dependent Child pursuant to a QMSCO, unless the child is an Eligible Dependent as defined above or as otherwise determined by the Trustees in their sole discretion.

The Plan will enroll for immediate coverage any "Alternate Recipient" who is the subject of an MCSO or an NMSO that is a QMCSO if the child named in the MCSO is not already covered by the Plan and such child is a Dependent Child, once the Plan has determined that the order or notice meets the standards for qualification set forth below. The Trustees have full discretion to determine if an order is a QMCSO under ERISA. If the order is found to be a QMCSO, the Plan will honor the order and continue the Dependent Child's coverage for so long as the child would have otherwise continued to qualify for coverage if the child actually resided with you and relied upon you for his or her financial support.

"Alternate Recipient" will mean any child of a Covered Person who is recognized under an MCSO as having a right to enrollment with the Plan as the Covered Person's Dependent Child. "MCSO" will mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan; or
- "NMSO" will mean a notice that contains the following information:
  - Name of an issuing state agency;
  - Name and mailing address (if any) of an employee who is a Covered Person under the Plan;
  - Name and mailing address of one or more Alternate Recipients (i.e., the Dependent Child(ren) of the Covered Person) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s); and
  - Identity of an underlying child support order.

"QMCSO" is an MCSO that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or Eligible Dependent is entitled from the Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each Alternate Recipient covered by the order;
- A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of the Plan.

In addition, an NMSO will be deemed a QMCSO only if it:

- Contains the information set forth above in the definition of NMSO;
- Identifies the coverage for which the Alternate Recipient is to be enrolled; and
- Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage, or upon the occurrence of certain specified events.

However, such an order will not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Covered Persons without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving an MCSO, the Plan will, as soon as administratively possible:

- Notify the Covered Person and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO; and
- Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving an NMSO, the Plan will:

- Notify the state agency issuing the notice with respect to the child whether coverage of the Dependent Child is available from the Plan and, if so:
  - Whether the Dependent Child is already covered by the Plan; and
  - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
  - Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan will:

- Establish reasonable, written procedures for determining the qualified status of an MCSO or NMSO; and
- Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

The Fund Office can provide more details about enrolling your children in such cases. A copy of the Plan's QMCSO Procedures are available free of charge from the Fund Office. To receive a copy of those procedures, please contact the Fund Office.

Military Duty in the United States Armed Forces (Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA))

If you enter the Armed Forces of the United States, you will be offered the opportunity to continue coverage under the Fund for yourself and your Dependents pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (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. However, you may continue your participation for a period of up to 24 months while you are serving in the armed services. If your period of military service is less than 31 days, your coverage (and your Dependent's coverage) will continue during the period of military service without charge. If the period of military services exceeds 31 days, you will be required to pay the applicable COBRA premium to continue coverage.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Fund Office has been notified by the employee in writing that they have been called to active duty in the uniformed services and provided a copy of the orders by the employee. The employee must notify the Fund Office as soon as possible but no later than 60 days after the date on which the employee 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 employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any Eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA continuation coverage, if the employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the employee (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 timeframes as are permitted under COBRA.

Paying for USERRA Coverage: If elected, 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 section for more details.

USERRA allows the employee to apply accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When an employee's accumulated eligibility is exhausted, the employee may pay for USERRA coverage under the self-pay rules of this plan. If the employee does not want to use his or her accumulated eligibility to pay for USERRA coverage, the employee can choose to freeze his or her eligibility and instead proceed to pay for the USERRA coverage.

In addition to USERRA or COBRA coverage, an employee or the 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 employee 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 service 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 eight hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years. The employee must notify the Fund Administrator in writing within the time periods listed above. Upon reinstatement, the employee'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.

Questions regarding your entitlement to USERRA leave should be referred to your Employer. Contact the Fund Office for further details regarding your continuation of coverage rights and obligations under USERRA.

Periods of Leave Under the Family and Medical Leave Act

The Family and Medical Leave Act, 29 USC §2601 et seq. ("FMLA") provides that if you work for an employer covered by that Act you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own Illness. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding Calendar Year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about FMLA and the terms on which you may be entitled to its coverage, contact your Employer.

Pension Self-Pay (No extension of coverage for Retirees over age 65 or Medicare-eligible)

A Pensioner who is under the age of 65 and who had accumulated at least 15 years of consecutive Local 807 Labor-Management Pension Fund (the "Pension Fund") pension credits earned immediately prior to retiring from the Pension Fund, can continue his or her Health Fund Benefits on a direct payment basis. Benefits end when each Covered Person (you or your Spouse) reaches 65 years of age or becomes eligible for Medicare (for any reason) under the Social Security Disability Act. If the Pensioner turns age 65 or becomes eligible for Medicare benefits and the Spouse is under 65 and not otherwise eligible for Medicare benefits, benefits under this Plan will continue for the Spouse and any Dependent Children until the earlier of the date the Spouse turns age 65 or becomes eligible for Medicare. However, benefits will end for any Dependent Children when he or she ceases to meet the definition of Dependent Child or for a Spouse upon the divorce from the Pensioner.

A Pensioner must elect single or family coverage. The election of single coverage may not be changed for any reason after the post-retirement benefits commence.

Pension Self-Pay and COBRA

You and/or your Dependents have the option of electing coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (referred to as "COBRA continuation coverage") instead of Pension Self-Pay Coverage. See the COBRA section for details. If the Pensioner does not elect COBRA continuation coverage at retirement within the required timeframes, he or she will no longer have any rights to COBRA continuation coverage, even upon loss of Pension Self-Pay Coverage. However, if the Spouse or any Dependent Children who are covered under the Pension Self-Pay Coverage experiences a COBRA qualifying event while covered under the self-pay provision (for example, if the Pensioner and his or her Spouse get a divorce or a child no longer meets the definition of Dependent), he or she will be offered a new COBRA election and will be entitled to continue coverage in accordance with COBRA for a period of up to 36 months from the date of the loss of coverage due to the qualifying event.

Special Retiree Death Benefit

The Health Fund will pay a $2,500 death benefit for funeral expenses if the deceased was a Covered Person of the Health Fund on the date he or she retired from the Pension Fund.

Extension of Coverage for a Surviving Spouse of a Retiree

The Spouse of a deceased Covered Person who was eligible for Pension Self-Pay on the date of the Covered Person's death will be eligible for coverage on a self-pay basis (for himself or herself and any Dependent Children) until he or she reaches age 65. The duration of this benefit will run concurrently with COBRA continuation coverage.

Summary of Coverage

Lifetime Maximum

There is no lifetime maximum under the Plan.

Your Health care Coverage Under the Plan

Your Health care Coverage under the Plan is provided through separate Hospital Coverage and Medical Coverage. Each type of coverage is briefly described below and is fully described in separate sections which follow and which can be quickly found in the Table of Contents. Please note that while an expense may not be covered under one of the benefits, it may be covered under the other. For example, Outpatient X-ray, laboratory and physical therapy expenses are not covered under the Hospital Coverage but are covered under the Medical Coverage.

HOSPITAL COVERAGE	
In-Network Only	Your Hospital Coverage is self-funded and provided by Empire BlueCross BlueShield and generally covers 90% of the cost of any Medically Necessary Inpatient stay, home health care, Hospice care and some Outpatient services. You are responsible for payment of coinsurance of 10%, as well as all applicable copayments. Such coinsurance will be subject to a maximum of $5,000 per Covered Person per Calendar Year. In all cases, you must comply with the Fund's utilization management program or your benefits will be reduced.
MEDICAL COVERAGE	
In-Network	Your In-Network Medical Coverage consists of benefits for services such as Physician visits, Outpatient treatments, surgery, anesthesia, X-rays and Laboratory, as well as other medical services. The Fund offers you access to MagnaCare's Preferred Provider Organization Medical Network (PPO). These In-Network medical benefits are subject to certain copayments as outlined more fully herein.
Out-of-Network	Medical coverage provided by Out-of-Network providers is subject to a $250 annual deductible for single coverage and a $750 annual deductible for family coverage. In addition, the Covered Person is responsible for payment of coinsurance of 30% for all Out-of-Network medical charges. Copayments also apply to certain medical charges as outlined more fully herein.

Hospital Benefits

INPATIENT SERVICES	
Summary of Benefits	**Summary of Member Cost**
Inpatient Hospitalization (Precertification is required) Hospital-provided services, Facilities, supplies and equipment related to: • Semi-private room and board • Anesthesia • Blood and blood products • General, special and critical nursing care • Intensive care • Kidney dialysis • Cardiac rehabilitation • Casts, splints and surgical dressings • Drugs and medications • Lab/X-rays • Oxygen and respiration therapy • Chemotherapy and Radiation therapy	**In-Network Hospital or in a Hospital outside Empire's service area which has an agreement with another BlueCross and BlueShield Plan:** • $250 Hospital admission copayment and 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) **Out-of-Network Hospital or Facility:** • Not covered and you are responsible for 100% of the charges
Physical Therapy, Physical Medicine or Rehabilitation	The Plan covers up to 30 days per Covered Person per Calendar Year. **In-Network Hospital or Facility:** • $250 Hospital admission copayment and 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) **In Out-of-Network Hospital or Facility:** • Not covered and you are responsible for 100% of the charges

EMERGENCY ROOM AND SKILLED NURSING FACILITY SERVICES	
Summary of Benefits	**Summary of Member Cost**
Emergency Room/Facility	**In-Network Hospital of Facility:** • $100 emergency room admission fee for sudden and serious medical conditions; If the Covered Person is admitted to the Hospital, the $100 emergency room fee is waived • Emergency room charges are also subject to 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) **Out-of-Network Hospital or Facility:** • $100 emergency room admission fee for sudden and serious medical conditions; If the Covered Person is admitted to the Hospital, the $100 emergency room fee is waived • Emergency room charges are also subject to 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) and all costs exceeding Empire's Allowed Amount
Skilled Nursing Facility	**In-Network Facility:** • 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) • Limit of 60 days per Covered Person per Calendar Year **Out-of-Network Facility:** • Not covered and you are responsible for 100% of the charges

OUTPATIENT SERVICES	
Summary of Benefits*	**Summary of Member Cost**
Services Provided in an Outpatient Hospital Department or Ambulatory Facility: • Surgery • Anesthesia and oxygen • Blood and blood products • Pre-surgical testing (if within seven days of surgery) • Chemotherapy and Radiation Therapy • Hemodialysis (kidney dialysis) • Mammography screening • Occupational, Speech and Vision Therapy (up to 30 Outpatient Facility visits per Covered Person per Calendar Year)	**In-Network Facility:** • $75 copayment; and • 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) **Out-of-Network Outpatient Hospital Department or Facility:** • Not covered and you are responsible for 100% of the charges
Home Health Care	**In-Network Provider:** • The Plan covers up to 200 visits per Covered Person per Calendar Year (subject to 10% coinsurance and a maximum of $5,000 per Covered Person per Calendar Year) **Out-of-Network Provider:** • Not covered and you are responsible for 100% of the charges
Hospice	**In-Network Provider:** • The Plan covers up to 210 days per Covered Person per lifetime, subject to 10% coinsurance (subject to a maximum of $5,000 per Covered Person per Calendar Year) **Out-of-Network Provider:** • Not covered and you are responsible for 100% of the charges

* This list contains examples of benefits and is not meant to be exhaustive.

MedReview Medical Management Program

Introduction

The Medical Management Program is provided through NYCHSRO/MedReview, Inc. ("MedReview") and can help you and your family receive health care in the most appropriate setting. This program can help reduce unnecessary hospitalizations and encourage the use of safe, cost-effective Hospital alternatives.

Program Physicians, nurses and health care professionals will work with you and your doctor to:

- Choose the most appropriate health care service or setting (Hospital, ambulatory surgery unit, home care);
- Explain the different health care choices available, particularly alternate care settings;
- Assure that a Patient's stay lasts only as long as is Medically Necessary; and
- Help arrange for any covered services needed after discharge.

When to Notify MedReview

Inpatient Hospital Benefits

You or a representative or family member must notify MedReview before any scheduled elective Hospital admission.

You also must notify MedReview:

- Within two business days following any unscheduled emergency admission, or
- As soon as possible after being admitted to the Hospital for a routine labor and/or delivery.

Outpatient Hospital Benefits

You must notify MedReview to certify the following Outpatient services or supplies:

- Durable Medical Equipment (DME) following a Hospital stay;
- Intravenous (IV) Therapy following a Hospital stay;
- Home Health Care following a Hospital stay;
- Occupational, Speech and Vision Therapy;
- Cardiac Rehabilitation and Respiratory Therapy;
- Chemotherapy and Radiation Therapy; and
- Colonoscopies and Endoscopies.

All services are subject to the requirement that they be Medically Necessary. If you receive a service or supply that is later determined not to be Medically Necessary, your benefits may be reduced or denied. By having the services or supplies pre-certified, you will be assured that they are covered by the Plan. If you fail to follow these procedures, you may be subject to greater out-of-pocket costs.

Pre-Admission Review

MedReview will conduct a pre-admission review before you enter the Hospital for a scheduled non-emergency admission. The pre-admission review will include:

- Reviewing the reason for admission;
- Reviewing the recommended course of treatment;
- Reviewing possible alternative treatment options, including ambulatory surgery or Outpatient treatment; and
- Discussing possible alternative treatment options, including ambulatory surgery or Outpatient treatment, with you and your doctor, if appropriate.

Ambulatory Surgery

Some surgical procedures can be performed without having to stay overnight in the Hospital. Ambulatory surgery offers a safe alternative to Inpatient Hospitalization, allowing you to recuperate at home.

If your Physician wants you to stay overnight in the Hospital for a surgical procedures, you must contact MedReview before admission. **You must call even if discharged the following day.**

If you schedule an operation on an ambulatory (non-admitted) basis and during or following surgery you develop complications that require admission to the Hospital, you must Contact MedRevew within two business days of the admission.

Continued Stay Review

While you are in the Hospital, a continued stay review by MedReview will be conducted, which includes:

- Working with the Hospital and your Physician to help make sure your stay lasts only as long as is Medically Necessary;
- Assistance in arranging for other covered services, such as home care following Hospital discharge, when needed; and
- Working with you and your family to identify and arrange continuing health care services for a prolonged Illness.

Medical Necessity Review

Most of the time, the MedReview staff can certify your admission or your continued stay without having to talk with your Physician. On occasion, it may be necessary for a program Physician to review your case and discuss it with your doctor.

If MedReview determines that the recommended course of treatment is not Medically Necessary or that another course of treatment would be preferable, the appropriate members of MedReview will discuss treatment options with your Physician. Usually, the doctors reach an agreement during this discussion about the necessity of the admission, the course of treatment or the appropriate length of stay in the Hospital. Either your Physician will agree that an alternative setting (such as an ambulatory surgery unit) is appropriate or the program's Physician will agree on the Inpatient setting.

If no consensus can be reached with your Physician, the Fund may find it necessary to deny coverage in whole or in part based upon the professional advice of the MedReview staff as to the appropriate Medically Necessary course of treatment.

Individual Case Management

If you and your family face a catastrophic Illness or Injury, the MedReview individual and personalized case management staff can provide assistance and support. You will have access to social workers and nurses who can help you and your family plan for post-Hospital care. Examples of the cases we can help with include:

- Cancer;
- Stroke;
- AIDS;
- Chronic Illness; and
- Spinal cord and other traumatic Injuries.

Newborn Infants Requiring Specialized Care

The birth of a new baby is usually a happy time. Hospitals typically discharge the mother and baby within a few days, but this is not always the case. Because of a complicated or premature delivery or an Illness discovered shortly after birth, the baby may remain in the Hospital after the mother returns home. You should call MedReview if your baby must remain hospitalized for any reason after the mother's discharge. Case managers are available to help you arrange for the often highly specialized care that may enable your baby to go home sooner than would otherwise be possible.

Penalty for Non-Compliance with MedReview Medical Management Program

Benefit Reductions

If you do not fully comply with the MedReview Medical Management Program, your benefits will be reduced. To avoid this possibility, you must:

- Notify MedReview before an elective admission;
- Contact MedReview within two business days after any emergency admission;
- Notify MedReview after being admitted to the Hospital for a routine labor and/or delivery; and
- Contact MedReview prior to receiving Outpatient supplies or services.

Remember, when you notify MedReview as required, you will be eligible for the full level of benefit coverage. However, if you do not comply with these requirements, you will be responsible for paying $100 per day of your Hospital bill, up to a maximum of $300.

Denial of Coverage

In some cases, the Fund may deny coverage in whole or in part based upon the professional advice of MedReview.

Summary

Notify MedReview by telephone before an elective admission. Make sure to have your Empire BlueCross BlueShield identification card available when you call. Also make sure that a family member or friend knows that MedReview must be called within two business days after an emergency Hospital admission.

MedReview Contact Information

MedReview can be reached at 800-688-2284, 24 hours per day, seven days a week.

MedReview's service is intended to give you more information about your health, the health care system, and alternate treatment possibilities. If you have further questions about the program, how it works, or what your responsibilities are, call MedReview at 800-688-2284.

Hospital Benefits (Empire BlueCross BlueShield)

Where to Find Network Providers

Empire's network gives you access to providers within Empire's operating area of 28 eastern New York State counties.

Inter-Plan Programs

Out-of-Area Services

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

Typically, when accessing care outside Empire's service area, you will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care providers. Empire's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers. Whenever you access covered health care services outside Empire's service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

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

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

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

Non-Participating Health care Providers Outside Empire's Service Area

Under certain circumstances, if Empire pays the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, Empire may collect such amounts directly from you. By participating in this Plan, you agree that Empire has the right to collect such amounts from you.

Your Liability Calculation

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

Exceptions

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

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established PPO networks of Hospitals and other health care providers. By presenting your Empire BlueCross BlueShield ID card to a Hospital participating in the BlueCard PPO Program, you receive the same In-Network benefits as you would receive from an Empire EPO network Hospital. The suitcase logo on your ID card indicates that you are a member of the BlueCard PPO Program. Call 800-810-BLUE (2583) or visit **www.bcbs.com** to locate participating providers.

BlueCard® Worldwide Program

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

- Call 804-673-1177, 24 hours a day, seven days a week, for the names of participating Hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®1 Access Number.
- Show your Empire BlueCross BlueShield ID card at the Hospital. If you are admitted, you will only have to pay for expenses not covered by your contract, such as copayments, coinsurance, and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

If you receive Outpatient Hospital care in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the health care provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any copayment and amount above the maximum Allowed Amount.

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

Emergency Care

If You Need Emergency Care

Should you need emergency care, your Empire Hospital Plan is there to cover you. Emergency care is covered in the Hospital emergency room. To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department of the Hospital to evaluate an Emergency Condition; and within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the Patient. With respect to an emergency medical condition, the term "Stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that 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).

Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your Physician or your Physician's backup.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a Hospital in Empire's network or the PPO network of another Blue Cross and/or Blue Shield plan. You pay a copayment, and then coinsurance, for a visit to an emergency room. This copayment is waived if you are admitted to the Hospital within 24 hours. Benefits for treatment in a Hospital emergency room are limited to the initial visit for an emergency condition.

Remember: You will need to show your Empire BlueCross BlueShield ID card when you arrive at the emergency room.

Tips for Getting Emergency Care

- If time permits, ask your Physician to direct you to the best place for treatment.
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. If the Hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard PPO program, your claim will be processed by the local plan. Be sure to show your Empire BlueCross BlueShield ID card at the emergency room. If the Hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a Hospital that participates in the BlueCard Worldwide program, simply show your Empire BlueCross BlueShield ID card. The Hospital will submit their bill through the BlueCard Worldwide Program. If the Hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

Please refer to the Medical Management section for details regarding precertification requirements.

What's Not Covered

These emergency services are not covered:

- Use of the Emergency Room:
  - To treat routine ailments;
  - Because you have no regular Physician;
  - Because it is late at night (and the need for treatment is not sudden and serious);
- Ambulance, ambulette or air ambulance (see Medical Benefits section for details on how emergency transport is paid).

Maternity Care

Obstetrical care in the Hospital or an In-Network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.

What's Covered

Following are additional covered services and limitations:

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the Hospital or a home health care agency within this time frame. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later;
- Parent education, and assistance and training in breast or bottle feeding, if available;
- Hospital services for circumcision of newborn males;
- Special care for the baby if the baby stays in the Hospital longer than the mother;
- Semi-private room; and
- Routine nursery care for well newborn is covered for up to 30 days during the mother's Medically Necessary confinement.

What's Not Covered

These maternity care services are not covered:

- Services that are not Medically Necessary;
- Private room;
- Out-of-Network birthing center Facilities; and
- Private duty nursing.

Remember: Use a network Hospital or Facility to receive the lowest cost maternity care.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Hospital Services

If You Visit the Hospital

Your Hospital Plan covers most or all of the cost of your Medically Necessary care when you stay at a network Hospital for surgery or treatment of Illness or Injury. No benefits are available when you use an Out-of-Network provider.

You are also covered for same-day (Outpatient or ambulatory) Hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or Hospital Outpatient surgical Facility;
- Require the use of both surgical operating and post-operative recovery rooms,
- May require either local or general anesthesia;
- Do not require Inpatient Hospital admission because it is not appropriate or Medically Necessary; and
- Would justify an Inpatient Hospital admission in the absence of a same-day surgery program.

Please refer to the MedReview Medical Management Program section for details regarding precertification requirements.

Tips for Getting Hospital Care

- If your doctor prescribes pre-surgical testing, have your tests completed within seven days prior to surgery at the Hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a Hospital bed and an operating room.
- If you are having same-day surgery, often the Hospital or Outpatient Facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Outpatient Hospital Care

What's Covered

Following are the covered services and limitations when performed in the Outpatient (same-day) care department or Facility:

- Blood and blood derivatives, for emergency care or ambulatory surgery;
- Mammogram (based on age and medical history):
  - Ages 35 through 39: one baseline;
  - Age 40 and older: one per year;
- Same-day and Hospital Outpatient surgical Facilities;
- Anesthesia and oxygen;
- Pre-surgical testing (if done within seven days of a schedule surgery);
- Chemotherapy and radiation therapy, including medications, in a Hospital Outpatient department or Facility. Medications that are part of Outpatient Hospital treatment if they are prescribed by the Hospital and filled by the Hospital pharmacy;
- Occupational, Speech and Vision Therapy, in a Hospital Outpatient department or Facility up to 30 visits per Calendar Year. Outpatient physical therapy is not covered;
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the Patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - At home, when provided, supervised and arranged by a Physician and the Patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered);
  - In a Hospital-based Facility;
  - In a freestanding Facility.

See "Hospital/Facility" in the Definitions section.

Please refer to the MedReview Medical Management Program section for details regarding precertification requirements.

What's Not Covered

These Outpatient services are not covered:

- Same-day surgery that requires the use of an Outpatient department of a Hospital or ambulatory Facility not **precertified** as Medically Necessary by the MedReview Medical Management Program where required;

- Routine medical care including, but not limited to:
  - Inoculation or vaccination;
  - Drug administration or injection, excluding chemotherapy;
- Collection or storage of your own blood, blood products, semen or bone marrow.

Inpatient Hospital Care

What's Covered

Following are covered services for Inpatient care:

- Semi-private room and board when:
  - The Patient is under the care of a Physician, and;
  - A Hospital stay is Medically Necessary.

Coverage is for unlimited days, subject to Medical Management Program review, unless otherwise specified for:

- Operating and recovery rooms;
- Intensive care, when Medically Necessary;
- Blood and blood products;
- General, special and critical nursing care;
- Special diet and nutritional services while in the Hospital;
- Cardiac care unit;
- Services of a licensed Physician or surgeon employed by the Hospital (if their services are included in Hospital charges);
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery;
  - Surgery on the other breast to produce a symmetrical appearance;
  - Prostheses;
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas;
  - The Patient has the right to decide, in consultation with the Physician, the length of Hospital stay following mastectomy surgery;
- Use of cardiographic equipment;
- Drugs, dressings and other Medically Necessary supplies;
- Social, psychological and pastoral services;
- Inpatient physical, occupational, speech and vision therapy including Facilities;

- Oxygen and respiratory therapy;
- Chemotherapy and radiation;
- Cardiac Rehabilitation.

Please refer to the MedReview Medical Management Program section for details regarding precertification requirements.

What's Not Covered

These Inpatient services are not covered:

- Private duty nursing;
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the Hospital's average charge for a semi-private room. The additional cost cannot be applied to your coinsurance;
- Diagnostic Inpatient stays, unless connected with specific symptoms that if not treated on an Inpatient basis could result in serious bodily harm or risk to life;
- Services performed in the following:
  - Nursing or convalescent homes;
  - Institutions primarily for rest or for the aged;
  - Rehabilitation Facilities (except for physical therapy or mental health or alcohol/substance abuse rehabilitation);
  - Spas;
  - Sanitaria;
  - Infirmaries at schools, colleges or camps;
- Any part of a Hospital stay that is primarily custodial or for a rest, cure or convalescent or sanitarium type care or care that is not curative or restorative and is not a form of medical treatment;
- Hospitalization or treatment for cosmetic surgery. However, cosmetic surgery will not include reconstructive surgery when it is coincidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or reconstructive surgery of the breast, when a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance. For a covered child, benefits are available for cosmetic or reconstructive surgery for a functional defect that is caused by a congenital disease or anomaly;
- Hospital services received in clinic settings that do not meet Empire's definition of a Hospital or other covered Facility. See "Hospital/Facility" in the Details and Definitions section;
- Residential treatment services are not covered (except as required under Mental Health Parity and Addiction Equity Act (MHPAEA).

Skilled Nursing and Hospice Care

If You Need Skilled Nursing or Hospice Care

You may be eligible to receive coverage through Empire's Hospital Plan for Inpatient care in a Skilled Nursing Facility or Hospice. Benefits are available in a Facility that has a participating agreement with Empire or another Blue Cross or Blue Shield Plan or in a Facility that is approved by the Joint Commission of Accreditation of Health Care Organizations.

Please refer to the Medical Management Program section for details regarding precertification requirements.

Skilled Nursing Care

What's Covered

You may be eligible for up to 60 Inpatient days per Calendar Year in a network Skilled Nursing Facility if you need medical care, nursing care or rehabilitation services when such care is, in their judgment, Medically Necessary and appropriate and approved by MedReview. Prior Hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor prescribes and provides:
  - A referral and written treatment plan;
  - A projected length of stay;
  - An explanation of the services the Patient needs; and
  - The intended benefits of care;
- Care is under the direct supervision of a Physician, registered nurse (RN), physical therapist, or other health care professional.

What's Not Covered

The following skilled nursing care services are not covered:

- Skilled nursing Facility care that primarily:
  - Gives assistance with daily living activities;
  - Is for rest or for non-medical care for the aged (e.g., nursing home);
- Convalescent care;
- Sanitarium-type care;
- Rest cures.

Hospice Care

Empire's Hospital Plan covers up to 210 days of Hospice care one time in a Covered Person's lifetime. Hospices provide medical and supportive care to Patients who have been certified by their Physician as having a life expectancy of six months or less. Hospice care can be provided in a Hospice, in the Hospice area of a participating Hospital, or at home, as long as it is provided by a participating Hospice agency.

What's Covered

Covered Hospice care services include:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN);
- Medical care given by the Hospice doctor;
- Drugs and medications prescribed by the Patient's doctor that are not Experimental and are approved for use by the most recent Physicians' Desk Reference;
- Physical, occupational, speech and respiratory therapy when required for control of symptoms;
- Laboratory tests, X-rays, chemotherapy and radiation therapy;
- Social and counseling services for the Patient's family, including bereavement counseling visits, until one year after death;
- Transportation between home and Hospital or Hospice when Medically Necessary;
- Medical supplies and rental of durable medical equipment;
- Up to 14 hours of respite care in any week.

Home Health Care

If You Need Home Health Care

Home health care can be an alternative to an extended stay in a Hospital or a stay in a Skilled Nursing Facility. You receive full coverage when you use an In-Network Provider.

Empire participating home health care agencies cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 800-553-9603.

Covered services and limitations:

- Up to 200 home health care visits per Calendar Year. A visit is defined as up to four hours of care. Your Physician must certify home health care as Medically Necessary and approve a written treatment plan;

- Home health care services include:
  - **Nursing care:** Intermittent or part-time home nursing care. The care must be provided by or under the direct supervision of a registered nurse;
  - **Intermittent or part-time care provided by home health aides.** Four hours of care equals one home care visit;
  - **Rehabilitation care:** Physical, speech or occupational therapy provided by the home health agency;
  - **Medical needs:** Medical supplies, drugs and medications prescribed by a Physician and laboratory services provided by or on behalf of a home health agency to the extent services would be covered if the covered member was in a Hospital or a Skilled Nursing Facility as defined by Medicare.

What's Not Covered

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care.

Physical, Occupational, Speech or Vision Therapy

If You Need Therapy

Please refer to the MedReview Medical Management Program section for details regarding precertification requirements.

Tip for Receiving Therapy

Ask for exercises you can do at home that will help you get better faster.

What's Covered

Following are covered services and limitations:

Inpatient Services

Physical therapy, physical medicine or rehabilitation services, or any combination of these on an Inpatient basis up to the plan maximums if:

- Prescribed by a Physician;
- Designed to improve or restore physical functioning within a reasonable period of time.

Outpatient Services

Occupational, speech or vision therapy, or any combination of these on an Outpatient basis up to the plan maximums (30 visits per Covered Person per Calendar Year) if:

- Prescribed by a Physician or in conjunction with a Physician's services;
- Given by skilled medical personnel in an Outpatient Facility;
- Performed by a licensed therapist who is acting within the scope of his/her provider's license or certification under applicable State law

What's Not Covered

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the Patient's current physical abilities;
- Outpatient physical therapy (see the Medical Coverage section for details on how this benefit is paid on an Outpatient basis).

Exclusions and Limitations Pertaining to Hospital Benefits

In addition to services mentioned under "What's Not Covered" in the prior sections, your Hospital Plan does not cover the following:

Dental Care

Benefits will not be provided for dental care or treatment. However, Empire will provide covered benefits for services necessary due to an Accidental Injury to sound natural teeth as a result of that accident; dental care or treatment necessary due to congenital disease or anomaly is covered.

Experimental/Investigational Treatments

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, Empire will not cover any treatment, procedure, drug, biological product or medical device or any hospitalization in connection with such technology if, in Empire's discretion, it is determined that such technology is Experimental or Investigational, unless otherwise recommended by an External Appeal agent.

"Experimental" or "Investigational" means that the technology is:

- Not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition; or
- Not generally recognized by the medical community as reflected in published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition;
- Empire will also not cover any technology or any hospitalization in connection with such technology if, in Empire's discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the Covered Person's particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Covered Person's condition. Empire will determine whether a technology is Experimental or Investigational at their discretion. Empire may apply the following five criteria in exercising their discretion and may in their discretion require that any or all of their criteria be met:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the Patient's particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, (e.g. Investigational device exemption or an Investigational new drug exclusion), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require any or all of the five criteria be met;

- Conclusive evidence from published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, supported by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
- Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects);
- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable;
- Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Government Hospital Services

- Services covered under government programs, except Medicaid or where otherwise noted;
- Government Hospital services, except:
  - Specific services covered in a participation agreement or special agreement between Empire and a government Hospital;
  - United States Veteran's Administration or Department of Defense Hospitals, except services in connection with a service-related Disability. In an emergency, Empire will provide benefits until the government Hospital can safely transfer the Patient to a participating Hospital.

Home Care

Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency

Inappropriate Billing

- Services usually given without charge, even if charges are billed;
- Services performed by Hospital or institutional staff that are billed separately from other Hospital or institutional services, except as specified.

Limit on Payment

Empire will not pay an amount that is more than a provider charged for covered care or that is more than the maximum Allowed Amount, nor will Empire credit such an amount toward the coinsurance.

Medically Unnecessary Services

Services, treatment or supplies not Medically Necessary in Empire's judgment. See Definitions section for more information.

Gender Reassignment surgery or procedures.

Non-Acute or Chronic Hospital Care

There are no benefits for any part of a Hospital stay that is primarily custodial, for a rest cure, for convalescent, sanitarium type care or care that is not curative or restorative and is not a form of medical treatment.

Prescription Drugs

All prescription drugs and over the counter drugs which do not require a prescription, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated.

Services by Unlicensed Providers

Any services provided by an unlicensed provider or services that are outside the scope of the license of the licensed provider who provided them are not covered.

Services Provided Pursuant to a Prohibited Referral

Any services provided by a Facility in which the referring Physician or his or her immediate family member has a financial interest or relationship.

Sterilization/Reproductive Technologies

- Reversal of sterilization;
- Assisted reproductive technologies including, but not limited to,:
  - In-vitro fertilization;
  - Artificial insemination;
  - Gamete and zygote intrafallopian tube transfer;
  - Intracytoplasmic sperm injection.

Travel

Travel, even if associated with treatment and recommended by a doctor

Vision Care

Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated.

War

Services for Illness or Injury received as a result of war, declared or undeclared, or any act of war.

Worker's Compensation, No-Fault Automobile Insurance or Other Statutory Programs

Services covered by Worker's Compensation, No-Fault automobile insurance or other statutory programs, policies or laws unless and until the Covered Person has exhausted all of the benefits available under these laws and programs. This exclusion applies even if the Covered Person does not claim benefits available under a statute or statutory program or policy or if the Covered Person is required to repay the benefits from money recovered in a related lawsuit or other proceeding.

Medical Benefits (MagnaCare)

The Fund provides coverage for Medical Benefits that are determined to be Medically Necessary. Each covered medical benefit discussed in this section of the SPD has different rules associated with it, so read each section carefully to understand the benefits to which you are entitled. The Fund provides In-Network benefits through MagnaCare's Preferred Provider Organization (PPO).

Covered Medical Benefits

The expenses for which you are covered are called "covered medical benefits." Covered medical benefits are Eligible Medical Expenses that are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the definitions section of this document); and
2. **Not services or supplies that are excluded** from coverage (as provided in the Exclusions section of this document); and
3. **Not services or supplies in excess** of any maximum Plan benefit as described in this section; and
4. **For the diagnosis or treatment of an Injury or Illness** (except where wellness/preventive services are payable by the Plan.

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have to satisfy some deductibles and pay some coinsurance, or make some copayments toward the amounts you incur that are covered medical benefits.

The Plan will not reimburse you for any expenses that are not covered medical benefits or are not considered Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Allowed Charge, not covered by the Plan, in excess of a maximum Plan benefit or payable on account of a penalty because of failure to comply with the Plan's Medical Management requirements as described earlier in this document.

The MagnaCare Preferred Provider Organization (PPO) Medical Network (In-Network Benefits)

If you receive medical services or supplies from a health care provider that has a contract with the MagnaCare PPO, you will be responsible for paying less money out of your pocket. Health care providers who are under a contract with the MagnaCare PPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional copayments you are responsible for paying, as payment in full.

When you use a network Physician, you must follow these steps in order to receive the maximum reimbursement:

- Check the MagnaCare PPO Provider Directory on MagnaCare's website or call MagnaCare directly at 800-235-7330 for the nearest network provider. The directory lists Physicians according to location and type of practice;
- Select a Physician from the network and schedule an appointment. Verify that he or she is participating in the MagnaCare PPO Network. Remember, because providers are periodically added to and dropped from the PPO network throughout the year, it is best if you ask your health care provider if they remain In-Network with the PPO or contact MagnaCare each time before you seek services;
- Although you may choose any Physician listed, it is recommended that you select a family Physician (or general internist or general pediatrician) as your primary care provider. Should you need a specialist, your primary care Physician would be in a better position to advise you about what type of specialist would be most appropriate for your medical condition. Keep in mind that it is still your responsibility to ensure such providers are In-Network.

For doctor visits, show your MagnaCare PPO identification card and pay the copayment listed on your identification card. Your copayment is $15 for a primary care doctor's visit and $30 for a specialist. In order to make sure your Physician uses a Facility for lab work that is a MagnaCare provider, make sure to ask your Physician at the time lab work is ordered. There is no copayment for X-rays or laboratory tests in a MagnaCare participating lab.

Out-of-Network (Also Called Non-Network, Non-PPO or Non-Participating)

- These terms refer to providers who are not contracted with the PPO Network. These Out-of-Network health care providers may bill a Plan Participant a non-discounted amount for any balance that may be due in addition to the Allowed Charge payable by the Plan, also called balance billing. To avoid balance billing, use In-Network Providers;
- If you receive Out-of-Network benefits, you will generally have to meet a deductible. The deductible is the amount you must pay each Calendar Year before the Plan begins to pay benefits. Each Calendar Year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual deductible and then the Plan begins to pay benefits. The Out-of-Network deductible is $250 for single coverage and $750 for family coverage;
- Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan accumulated on a Calendar Year basis. Only Eligible Medical Expenses up to the Allowed Amount can be used to satisfy the Plan's deductibles. As a result, non-Eligible Medical Expenses described above or those that exceed the Allowed Amount do not count toward the deductibles. In-Network expenses and penalties for failure to obtain preauthorization for services do not accumulate to meet a deductible. Once you've met your annual deductible, the Plan generally pays 70% of the Allowed Amount of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest (generally 30%). The part you pay is called the coinsurance.

Medical Benefits

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Physician Visits • In Office • Home • Specialist Consultation: The Fund will pay for one specialist consultation per specialty every six months. • Inpatient: Visit: One visit per day per specialty per Covered Person	• Primary Care Physician: $15 copayment • Specialist: $30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Surgery (Inpatient, Outpatient Hospital or Ambulatory) The Fund pays scheduled allowances for surgery performed in or outside a Hospital. • These allowances include the operative procedure as well as routine care rendered during the aftercare period. • Note that the Hospital or Facility fee is paid under the Empire Hospital Plan provisions.	Paid in full according to the contract rate with MagnaCare	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Anesthesia	Paid in full according to the MagnaCare contracted rate	60% of the anesthesia fee (not to exceed 40% of the surgical charge) for the services of an anesthesiologist when care is provided for covered surgeries

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Maternity Care (Physician/Provider Charges; Hospital or Facility Fees are payable under the Empire Hospital Plan) The Fund's scheduled allowance for delivery of a newborn child includes all doctor visits before and after the delivery if the expectant mother is an Eligible Employee or the Spouse of an Eligible Employee and is covered by the Fund at the time of delivery. ***Nurse-Midwife:*** If the maternity care services are performed by a nurse-midwife, payment will be made only if the following qualifications are met: • The nurse-midwife must be certified and a member of the American College of Nurse-midwifery; • The Patient must be cared for in an approved Hospital. Home delivery by a nurse-midwife will not be covered; and • Prenatal, delivery and post-delivery care must be supervised by a licensed Physician approved for obstetrical care at the Hospital where the nurse-midwife serves. The licensed Physician is reimbursed only in the event of complications. The total Physician and nurse-midwife reimbursement may not exceed the scheduled amount for the service.	$15 copayment per Physician visit	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Diagnostic X-Rays and Laboratory Examinations The Plan pays for technical and professional fees, diagnostic X-rays and laboratory services: • Common Laboratory services include diagnostic testing related to chemistry, hematology, urinalysis, toxicology, microbiology, blood banking, anatomic pathology–surgical pathology and/or cytopathology • Common radiology services include chest X-ray, abdomen/kidney X-ray, spine X-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry	Paid in full (no charge for diagnostic X-rays and laboratory examination performed at a participating diagnostic laboratory)	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Visiting Nurse Service • The Funds pays an allowance as per fee schedule for a visit by a registered nurse from an accredited Visiting Nurse Service. • Visiting Nurse Service is subject to pre-certification from MedReview and a Medically Necessary determination per each treatment.	Paid in full according to the MagnaCare contracted rate	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Ambulance Service Ground vehicle emergency transportation: • To the nearest appropriate Facility as Medically Necessary for treatment of a medical emergency; • For Medically Necessary inter-health care Facility transfer (e.g. transfer from one Hospital to another Hospital or trip to and from one Hospital to another in order to obtain a special test/procedure)	Paid in full Note that emergency transport (ambulances) are generally not available In-Network and benefit will be payable at the Out-of-Network level	Covered up to $500 per trip

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Emergency Room Treatment: Physician/Provider Charges • Charges incurred by a Covered Person during an emergency room stay for the treatment of an Illness or Accidental Injury if the emergency room visit is deemed to be covered by Empire Blue Cross. • Ancillary charges, i.e., interpretation of X-rays, lab tests and sutures. • The Fund will only pay the amount paid under the Plan for an In-Network or Out-of-Network doctor's office visit if emergency treatment is sought for a less serious Illness (e.g. earache or sore throat). • Please review the Hospital Benefits section of this SPD for corresponding Emergency Room benefit coverage.	• Paid in full if Empire covers the Emergency Room visit • If Empire does not cover the Emergency Room visit, paid like an office visit	• Paid in full up to the Allowed Amount if Empire covers the Emergency Room visit; you may be balanced billed for charges that exceed the Fund's Allowed Amount • If Empire does not cover the Emergency Room visit , 30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Acupuncture Maximum of 30 treatments per Covered Person per Calendar Year.	$30 copayment per treatment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Allergy Testing and Injections The following are covered under the Plan: • Allergy testing to a maximum of $250 per Covered Person per Calendar Year. • Allergy injections up to a maximum of 30 injection per Covered Person per Calendar Year. The Fund does not cover an office visit on the same day as the injection.	$30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Chiropractic Care Subject to the Fund's allowance of 30 treatments per Covered Person per Calendar Year.	$30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Physical, Occupational, Speech and Language, Lymphedema Therapy, and Cardiac Rehabilitation Maximum of 30 treatments per Covered Person per Calendar Year	$30 copayment per treatment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Kinetic and Opthoptic Therapy Subject to the Fund's allowance of 18 treatments per Covered Person per Calendar Year.	$30 copayment per treatment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Chemotherapy and Radiation Therapy Chemotherapy drugs and supplies administered under the direction of a Physician. If chemotherapy is delivered in a Hospital or Outpatient Facility, it will be covered under the Hospital Benefits.	$30 copayment per treatment/office visits	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Dermatology • All acne surgery is subject to a $450 maximum per Covered Person per Calendar Year. • Intralesionial injections are subject to a $250 maximum per Covered Person per Calendar Year. • Cryosurgery to treat acne is subject to $350 maximum per Covered Person per Calendar Year.	$30 copayment per treatment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Injections and Related Treatment • All **ophthalmic diagnostic imaging** is subject to the Fund's allowance of one treatment per Covered Person per Calendar Year. • All **epidural injections and intrabursal injections** are subject to the Fund's allowance of three treatments per Covered Person per Calendar Year. • All **trigger point injections and papaverine injections** are subject to the Fund's allowance of four treatments per Covered Person per Calendar Year. • All **arthocentesis** is subject to the Fund's allowance of six (three per side) treatments per Covered Person per Calendar Year. • All **sclerotherapy injections** are subject to the Fund's allowance of 12 treatments per Covered Person per Calendar Year. • All **ultraviolet treatments** are subject to the Fund's allowance of 12 treatments per Covered Person per Calendar Year.	$30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Orthotics One orthotic per Covered Person per lifetime	$30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Durable Medical Equipment (DME) • Coverage is provided for Medically Necessary Durable Medical Equipment. • All requests for DME must be reviewed by the Fund prior to rental or purchase. If you do not obtain prior approval, your claim will be denied. • Plan does not pay for replacement of DME, includes the replacement of lost, missing, stolen, duplicate or personalized DME.	$30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Annual Physical Examinations • You, your Spouse and Dependent Children are entitled to one annual physical examination performed through the Professional Evaluation Medical Group (PEMG) or your regular primary care Physician. • To find a PEMG location near you, or to make an appointment, call any weekday between 9 a.m. and 5 p.m. at 516-935-4378	$15 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Mammography Screening	MagnaCare Participating Radiology Center/ Laboratory: Paid in full according to the MagnaCare contracted rate	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

Benefit Description	**In-Network Benefit** Your cost sharing if you use a MagnaCare (In-Network) Provider	**Out-of-Network Benefit** Your cost sharing if you use a Non-MagnaCare (Out-of-Network) Provider
Podiatry The Fund pays for an allowance of four routine podiatric (foot) visits per Covered Person per Calendar Year. The Fund pays for an allowance of $1,000 per year for in-office surgeries for routine foot care per Covered Person per Calendar Year. The Fund's allowance for major podiatric surgeries (non-routine foot care) is per the Fund or MagnaCare's schedule of fees depending on the surgery and providers.	$30 copayment	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

Coverage for Breast Reconstruction in Connection with Mastectomy

If you or your Eligible Dependent is receiving benefits in connection with a mastectomy and you elect breast reconstruction in connection with the mastectomy, you are entitled to coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses (i.e., breast implants) and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage for the mastectomy-related services or benefits required under the Women's Health and Cancer Rights Act will be subject to the same deductible, copayment, coinsurance, and annual maximum provisions that apply to other medical or surgical benefits provided under this Plan.

Medical Limitations

Limitations and Exclusions are set forth in the "General Health Care Coverage Exclusions" section. Please bear in mind that no benefits will be paid for any services that are deemed by the Trustees:

- To be not Medically Necessary;
- To exceed the Allowed Amount charge recognized by the Fund or any of its Third-Party Suppliers;
- To be Experimental or Investigational; or
- To be excluded under the terms of this Plan.

The Fund will not be obligated to reimburse any expense for any service that is determined, in the sole discretion of the Trustees, to not be covered by the Fund or which is excluded by the provisions of this Booklet. Limitations on reimbursement or payment set forth in this Booklet will be applied to any applicable claim.

Infertility Related Services

The Fund pays an allowance for all infertility related services, including hospitalization, medical and medication, up to a maximum of $10,000 per lifetime. This Medical Benefit is subject to applicable copayments and coinsurance depending on whether the location where the medical treatment is performed and the type of provider rendering the treatment are considered to be In-Network or Out-of-Network. This includes all pre-and post-surgery services and supplies including prescription drugs.

Transplants

The Fund pays eligible expenses for Medically Necessary kidney, liver, heart, bone marrow and cornea transplants.

Mental Health Benefits

All Covered Persons are eligible for the Fund's mental health care benefits as provided in this Booklet.

Facilities and Providers

For Facility-based programs (either Inpatient or Outpatient), you may use any network Facility that is in the Empire BlueCross BlueShield or TCS network. No Out-of-Network benefits are payable under this Plan for Hospitals or Outpatient Facilities.

For office visits, you may use any provider who is in the TCS or MagnaCare Network or see an Out-of-Network provider.

Teamster Center Services (TCS) Facilities

Covered Persons are eligible to utilize Teamster Center Services (TCS) for the mental health benefits. A TCS representative will assist you in finding an appropriate TCS mental health provider. You or your Employee Assistance Program representative may contact TCS at 800-433-4827.

Empire BlueCross BlueShield Facilities

Inpatient benefits for Empire BlueCross BlueShield Facilities require pre-certification through the MedReview Medical Management Program before any scheduled elective Hospital admission. Please refer to the "MedReview Medical Management Program" section of this SPD for more information concerning MedReview.

MENTAL HEALTH BENEFITS		
	In-Network Provider	**Out-of-Network Provider**
Inpatient Hospital Stays ***Pre-Certification is required for Inpatient Hospital Stays through MedReview Medical Management Program for Empire providers***	Inpatient Hospital stays are paid at 90% of the TCS or Empire BlueCross BlueShield EPO contracted rate after a $250 per admission copayment has been satisfied You are responsible for the 10% coinsurance (up to the $5,000 annual out-of-pocket maximum) You may utilize any TCS or Empire BlueCross BlueShield EPO Participant Facility	Not covered except in an emergency

MENTAL HEALTH BENEFITS		
	In-Network Provider	**Out-of-Network Provider**
Inpatient Physician Visits	Inpatient Physician Visits are covered at 100% of the TCS or MagnaCare contracted rate	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Outpatient Office Visits/ Physician Services	$30 copayment per visit You may utilize any TCS or MagnaCare provider	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Outpatient Facilities	Paid at 90% of the TCS or Empire BlueCross BlueShield EPO contracted rate after $75 copayment per day You are responsible for the 10% coinsurance (up to the $5,000 annual out-of-pocket maximum) You may utilize any TCS or Empire BlueCross BlueShield EPO Participant Facility	Not covered

Alcohol and Substance Abuse Benefits

Eligibility

These benefits are available to **active Eligible Employees only.** A Spouse and/or Dependent Child of an active Covered Person are not covered for this benefit.

Facilities and Providers

For Facility-based programs (either Inpatient or Outpatient), you may use any network Facility that is in the Empire BlueCross BlueShield or TCS network. No Out-of-Network benefits are payable under this Plan for Hospitals or Outpatient Facilities.

For office visits, you may use any provider who is in the TCS or MagnaCare Network or see an Out-of-Network provider.

Teamster Center Services (TCS) Facilities

Covered Persons are eligible to utilize Teamster Center Services (TCS) for alcohol and substance abuse benefits. A TCS representative will assist you in finding an appropriate TCS alcohol or substance abuse provider. You or your Employee Assistance Program representative may contact TCS at 800-433-4827.

Empire BlueCross BlueShield Facilities

Inpatient benefits for Empire BlueCross BlueShield Facilities require pre-certification through the MedReview Medical Management Program before any scheduled elective Hospital admission. Please refer to the "MedReview Medical Management Program" section of this SPD for more information concerning MedReview.

ALCOHOL AND SUBSTANCE ABUSE BENEFITS		
	In-Network Provider	**Out-of-Network Provider**
Inpatient Hospital Stays *Pre-Certification is required for Inpatient Hospital Stays through MedReview Medical Management Program.*	Inpatient Hospital Stays are paid at 100% of the TCS or Empire BlueCross BlueShield EPO contracted rate You may utilize any TCS or Empire BlueCross BlueShield EPO participating Facility	Not covered
Inpatient Physician Visits	Inpatient Physician Visits are paid at 100% of the TCS or MagnaCare contracted rate	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family

ALCOHOL AND SUBSTANCE ABUSE BENEFITS		
	In-Network Provider	**Out-of-Network Provider**
Outpatient Office Visits/Physician Services	Paid at 100% of the TCS or MagnaCare contracted rate	30% coinsurance of Allowed Amount after annual deductible of $250 single/$750 family
Outpatient Facilities	Paid at 100% of the TCS or Empire BlueCross BlueShield EPO contracted rate You may utilize any TCS or Empire BlueCross BlueShield EPO participating Facility	Not covered

Prescription Drug Coverage

Introduction

Your prescription drug plan is administered by Express Scripts, Inc. ("Express Scripts") which has recruited a wide network of In-Network pharmacies.

Your prescription drug coverage is divided into two programs. The first program is a **retail program**, covering up to a 30-day supply for all medications which require a prescription by either state or federal law and are prescribed by a licensed practitioner.

The second program is a **mail order program** covering the same drugs but offering a mail order service for a 60-day supply of prescription maintenance drugs. This service is typically used by people with chronic ailments such as high blood pressure, heart conditions, asthma, diabetes, arthritis, etc.

Prescription drugs purchased under either the retail or mail order program will be subject to a copayment.

Generic Drugs

A generic drug is defined by its official chemical name and is an equivalent to a brand name medication. All drugs, including generics, must meet the same Food and Drug Administration (FDA) standards for quality, strength, purity, effectiveness, stability, and safety. In most cases, there is a great difference in price between brand name and generic drugs.

Preferred Brand Name Drugs and Non-Preferred Brand Name Drugs

A preferred brand name drug is on a list of preferred medications. This is a list of carefully selected medications that have been selected by Express Scripts based on their clinical effectiveness and opportunity for cost savings to the Plan. Under the preferred brand name program, the Plan requires a lower copayment for preferred brand name medications, and a higher copayment for non-preferred brand name medications. Contact Express Scripts for commonly prescribed preferred name medications and alternatives to non-preferred brand name medications (you can reach them at the phone number found on your ID).

If your doctor states that there is a medical reason for prescribing only a brand name drug rather than a generic alternative, then you must call Express Scripts prior to purchasing the drugs to make arrangements to have the medical necessity for using the brand name drug confirmed by Express Scripts. With advance Express Scripts' approval, you will be subject to the $25 copayment only.

The Retail Program

The Benefit

Subject to the copayment amount, you, your Spouse and Dependent Children are covered for the cost of prescription medications prescribed by a licensed practitioner. Prescriptions will be dispensed as written by the Physician up to a 30-day supply.

The Copayment

- $15 for retail generic prescription drugs;
- $25 for retail preferred brand name prescription drugs;
- $50 for retail non-preferred brand name prescriptions; and
- If a prescription requires a brand name drug when a generic alternative is available, your copayment will be either $25 (the retail preferred prescription copayment) or $50 (the retail non-preferred brand name prescription copayment) **plus** the difference in cost between the generic alternative and the prescribed brand name drug.

Using The Retail Program

Present your Express Scripts card and the prescription to the pharmacist. When you present your identification card, you pay the pharmacist the applicable copayment. If you do not have your card, you may have the pharmacist call Express Scripts to verify your eligibility.

If you do not use an Express Scripts pharmacist: If you fill your prescription at an Out-of-Network pharmacy you must pay the pharmacist and then submit a reimbursement claim form to Express Scripts. Claim forms are available from the Fund Office or from the **www.express-scripts.com** website. Use one claim form for each prescription. Complete the form and mail it to the address printed on the reverse side. The claims will be reimbursed as per Express Scripts' allowance minus the applicable copay.

The Mail Order Program

The Benefit

Subject to the copayment amount, you, your Spouse and Dependent Children may use a mail order prescription drug service for receiving a 60-day supply of maintenance drugs through the mail. This service covers any prescription medication your doctor requests (except those cited below as prescription drug plan exclusions) to be taken on a long-term continual schedule.

The Copayment

- $30 for mail order generic prescription drugs;
- $50 for mail order preferred brand name prescription drugs;
- $100 for mail order non-preferred brand name prescriptions; and
- If a prescription requires a brand name drug when a generic alternative is available, your copayment will be either $50 (the preferred brand name drug copayment) or $100 (the non-preferred brand name drug copayment) **plus** the difference in cost between the generic alternative and the prescribed brand name drug.

Using the Mail Order Program

The mail order plan is administered by Express Scripts Mail Order Program. Call Express Scripts at 877-852-4060 or the Fund Office at 718-274-5353, or go to **www.express-scripts.com** to obtain a mail order envelope. Fill out the information and enclose your doctor's prescription for up to a 60-day supply.

Your initial prescription order should be delivered by UPS or the U.S. Mail within eight to 11 business days after the Express Scripts Mail pharmacy receives your prescription. You will receive another mailing envelope with your shipment for the next refill. **Remember to send in your reorder about two weeks before your medication is due to run out**. Refills are usually delivered in less time.

- If you do not receive your medication within two weeks, contact Express Scripts. Give your name, the name of your doctor, the type of prescription and the date you mailed it to the Express Scripts pharmacy. An immediate trace will be made and, if necessary, an Express Scripts representative will contact your doctor to arrange for a new prescription. Prescriptions for mental health care and alcohol and substance abuse require a $5 copayment subject to the same mandatory generic provisions that apply to all other prescription drugs covered under the Plan.
- Insulin is covered by prescription only.
- All refills will be dispensed according to your Physician's directions.
- **There is a six-month supply limitation for habit-forming analgesics.**

Prescription Drug Plan Exclusions

Not covered under either the retail program or the mail order program are:

- Diet pills, vitamins of any kind, allergy serums;
- Stimulants or any injectable medications (except insulin);
- Oral contraceptives;
- Erectile dysfunction medications;
- Medications that can be legally obtained without prescription;
- Support garments or other non-medicinal substances;
- Investigational or Experimental drugs;
- Unauthorized refills;
- Prescriptions covered without charge under federal, state or local programs including Worker's Compensation; and
- Medications for cosmetic purposes (e.g. Rogaine for hair restoration and Retin-A for individuals over 25 years old).

The Board of Trustees will review this list from time to time, in light of new drugs approved by the FDA and other considerations, and may revise the list of non-covered drugs. Please contact Express Scripts for the most up-to-date information on which drugs are not covered by the Plan as well as which ones require advance authorization.

Dental Benefits

You have the choice of care under the Dental Plan. You can choose any Dentist you prefer, in which case your coverage will be based upon the Fund's practices as explained below. Alternatively, you can choose an In-Network Self-Insured Dental Services MetroDENT (S.I.D.S.) provider. **Since your dental charges are likely to exceed the reimbursements provided by the Fund, you will realize a significant savings in the cost of your dental care when you use a S.I.D.S. provider**. The S.I.D.S. provider services are also described below.

Dental benefits are treated as a stand-alone (or excepted) benefit under HIPAA and the PPACA. Employees may decline dental benefits. If you wish to opt out of dental benefits, contact the Fund Office.

The Fund's Dental Coverage

Eligibility

You, your Spouse and your Dependents are eligible for dental benefits when you are eligible for Health Fund coverage.

Annual Deductible

There is no annual deductible.

Annual Maximum

There is an annual maximum of $2,500 for each Covered Person.

Copayments for Specified Procedures

Participants are required to pay copayments of $10 for the following procedures:

- Amalgam Fillings;
- Composite Fillings.

Participants are required to pay copayments of $50 for the following procedures:

- Crowns;
- Root Canal Therapy;
- Gingivectomy;
- Osseous Surgery;
- Complete Dentures;
- Partial Dentures;
- Abutment Crowns (Fixed Bridgework);
- Pontic Crowns (Fixed Bridgework).

Orthodontic Benefit

The Fund will pay up to total of $2,900 in a person's lifetime for orthodontic expense for Covered Persons up to age 19. The annual maximum also applies.

Waiting Period

During the first six months of eligibility, there is no coverage for Dentures, Crowns, Bridgework or Orthodontic treatment for any Covered Person.

Covered Expenses

Covered Expenses include charges incurred for the performance of dental services provided for in the schedule of Covered Dental Expenses (which is available from the Fund Office), when the dental service is performed by or under the direction of a duly licensed Dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

Coverage is only provided for Reasonable and Customary dental charges based upon schedules used by the Fund. As will be explained below, if you want to limit your unreimbursed expenses, you can either use the S.I.D.S. Plan or obtain a Pre-Treatment Review in order to understand the costs you will incur before you have the treatment.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- For fixed bridgework and removable dentures, performance of the service starts when the first impressions are taken and/or abutment teeth are prepared;
- For a crown, performance of the service starts on the first date of preparation of the tooth involved;
- For root canal therapy, performance of the service starts when the pulp chamber of the tooth is opened.

Limited Benefits After Loss of Coverage

An expense that is actually incurred after a person's benefits coverage is terminated will be covered, but only if:

- The treatment was started before that person's coverage terminated and completed within one month after coverage was terminated;
- For crowns, fixed bridgework and full or partial dentures:
  - A pre-treatment authorization was issued and impressions were taken and/or;
  - Teeth were prepared while that person was a Covered Person and the device was installed or delivered within one month after that person's eligibility terminated;
- For root canal therapy:
  - The pulp chamber of the tooth was opened while that person was eligible for benefits.

Except as specifically stated above, Dental Services started or completed after the termination of coverage will not be covered.

Pre-Treatment Review

Pre-Treatment Review allows you and your Dentist to determine in advance of treatment what benefits are provided by the Fund's Dental Program.

If you would like to file a claim for Pre-Treatment Review, your Dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it together with the necessary X-rays and other supporting documentation to:

Self-Insured Dental Services (S.I.D.S.)
Dept. 75
P.O. Box 9005
Lynbrook, NY 11563-9005
Telephone: 516-396-5500 or 718-204-7172.

You and your Dentist will then receive a report showing the amount the Fund will pay for each procedure. If any portion of the proposed treatment is not covered, that will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your Dentist before you begin the treatment, and use the Pre-Treatment Review if you have any questions about whether the expense will be covered by the Fund.

Once approved, a Pre-Treatment Review that was submitted by one Dentist will remain valid even if you elect to have some or all of the work completed by another Dentist.

An approved Pre-Treatment Review for a proposed course of treatment will be honored for one year after issuance if:

- You are still covered by the Fund for benefits when the work is actually done (including coverage under one of the special Extension of Benefit rules described above); and
- There has been no significant change in the condition of your mouth after the approval of the Pre-Treatment Review was issued.

Payment will be made in accordance with the Fund's allowances and limitations in effect at the time services are provided. **Please be aware that a Pre-Treatment Review is not a promise of payment.**

Fund Review – Alternate Benefits May Be Recommended

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. In these instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive alternative course of treatment. The Fund reserves the right to decline to pay for any course of treatment if the Fund determines that an alternative course of treatment will provide an acceptable result at a lower cost.

This should in no way be considered a reflection on your treating Dentist's recommendations. By using the Pre-Treatment Review procedures you and your Dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a Pre-Treatment Review, the benefits paid by this Dental program may be based on the cost of the less expensive treatment.

Expenses Not Covered

No payment will be made for any expenses related to:

- Treatment solely for the purpose of cosmetic improvement;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed;
- Dentures, crowns, bridgework or orthodontic treatment during the first six months of eligibility;
- Replacement of a bridge, crown or denture that is or can be made usable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - Change vertical dimension; or
  - Diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
  - Stabilize periodontally involved teeth;
- Multiple bridge abutments;
- A surgical implant of any type;
- Dental services that do not meet common dental standards;
- Services not included as Covered Dental Expenses in the schedule of Covered Dental Expenses (which is available from the Fund Office);
- Services for which benefits are not payable according to the "General Limitations" section;
- General Anesthesia, except for oral surgeons, periodontists and pedodontists.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- For or in connection with services or supplies resulting from an Accidental Injury and which are deemed to be the responsibility of a third party;
- For or in connection with an Injury arising out of, or in the course of any employment for wage or profit;

- For or in connection with a Sickness or Injury which is covered under any Worker's Compensation or similar law;
- For charges made by a Hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any insurance;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges that would not have been incurred if the person had no insurance, including services provided by a member of the Patient's immediate family;
- To the extent that they are more than Reasonable and Customary charges;
- Charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program;
- For or in connection with Experimental procedures or treatment methods not Medically Necessary as defined by the Plan.

S.I.D.S. MetroDENT Dental Network Program

The S.I.D.S. Network is offered to you to assist you in substantially reducing, or perhaps even eliminating, the non-reimbursed portion of your dental bill. Since your dental charges are likely to exceed reimbursements provided under the Fund, you will realize a significant savings in the cost of your dental care when you use an In-Network S.I.D.S. provider.

When you use an In-Network Provider you will not incur any out-of-pocket expenses except:

- For services that exceed or are not included as scheduled benefits, for example, where procedure frequency limitations have been met or the service involves cosmetic restorations. In these cases, if the In-Network Dentist's charges exceed the Maximum Charges as stated in the Schedule, you will be responsible for the difference;
- For certain procedures not covered by the Fund;
- For certain procedures that are subject to either a $10 or $50 copayments, as set forth above;
- For charges which exceed the $2,500 yearly maximum.

The Directory of In-Network Dentists

This directory includes the names, addresses and telephone numbers of general practitioners, periodontists, endodontists, oral surgeons, orthodontists, pedodontists and prosthodontists. **Although several Dentists may practice at the same location, only a Dentist whose name appears on the list is an In-Network Dentist**.

In-Network Dentists are added to the network and deleted from the network from time to time. At any time, you can find out if any Dentist is an In-Network Dentist by contacting S.I.D.S. and they will send a directory to you at no cost, on request.

Remember, because providers are added to and dropped periodically, it is best if you ask your provider if they are still in the S.I.D.S. network or contact S.I.D.S. each time before you seek services.

Selecting a Dentist

There are no restrictions on the use of an In-Network Dentist. You are free to select the Dentist or dental specialist of your choice. And of course, each family member may select his or her own Dentist. You may utilize the services of an In-Network specialist, whether or not you utilize the services of an In-Network general Dentist for your routine care. It is important to understand that the Fund does not recommend or endorse any particular Dentist. You are responsible to select the Dentist of your choice, In-Network or Out-of-Network, and you should exercise the same care and apply the same criteria in selecting an In-Network Dentist that you would in selecting an Out-of-Network Dentist.

Scheduling an Appointment

After selecting a Dentist from the directory, call the dental office for an appointment. Identify yourself as being covered by the S.I.D.S. Program through the Local 807 Labor-Management Health Fund when scheduling your appointment. **Due to the fact that there are occasional additions and deletions of Dentists, please verify that the Dentist is still In-Network when scheduling your appointment**.

If you have any questions, you can either contact the Fund Office at 718-274-5353 or S.I.D.S. at 800-537-1238. You can also access the S.I.D.S. website at **www.asonet.com**.

Vision Benefits

You, your Spouse and your Dependent Children, and eligible Pensioners are entitled to an optical allowance once every 12-month period through an extensive network of doctors who participate in the Davis Vision network.

Vision benefits are treated as a stand-alone (or excepted) benefit under HIPAA and the PPACA. Employees may decline vision benefits. If you wish to opt out of vision benefits, contact the Fund Office.

You are entitled to a comprehensive eye examination and either a complete pair of eyeglasses from Davis Vision's "Tower Collection" or an allowance toward contact lenses from the provider's selection.

To be eligible for optical benefits, a Pensioner has to meet the following requirements:

- Have been working in Covered Employment under the jurisdiction of Local 807 at the time of retirement; **and**
- Be age 65 or older and have at least 15 years of Local 807 Pension Fund pension credits; **or**
- Be any age with at least 30 years of Local 807 Pension Fund pension credits.

This benefit is not available to a Pensioner's Spouse or other Dependents.

When you or a family member need vision care services you may obtain a listing of providers by calling 800-999-5431. Please have your Social Security number available when calling.

You will be responsible for any charges in excess of the allowable credits if you choose a frame or contact lenses that are not from Davis Vision's "Tower Collection."

If you wish, you may receive services from an Out-of-Network provider. If you choose an Out-of-Network provider, you must pay the provider and then have the provider complete the applicable sections of your direct reimbursement form. For Out-of-Network services, you are entitled to reimbursement of up to $25 for an eye examination and up to $75 for frames and lenses or contact lenses **after you submit your claim form to the Fund Office**.

Death Benefits

General

If an Eligible Employeeor the Spouse of an Eligible Employee loses his or her life, the Death Benefit described below will be paid in addition to any other Death Benefit that may be payable pursuant to the Fund. No benefit will be paid unless the Covered Person is insured at the time of the death for which benefits are claimed.

- Death of an Eligible Employee $15,000
- Death of the Spouse of an Eligible Employee $5,000

Beneficiary

A Death Benefit will be paid to the Eligible Employee's or Spouse's surviving designated beneficiary. If no beneficiary has been designated, or if no designated beneficiary survives the Eligible Employee, the benefit will be paid to the Covered Person's surviving Spouse, or if no Spouse survives, to the Covered Person's surviving children *per stirpes*, (meaning the share of a deceased child will go to his or her children and not the remaining children of the Covered Person) or if no such descendant survives, to the Eligible Employee's estate. A beneficiary who has been determined by a court of competent jurisdiction to have criminal responsibility for having "intentionally" caused such death will be deemed to have predeceased the Eligible Employee.

Funeral Expenses

The Fund may pay up to 25% of the Death Benefit to reimburse the payment of the Covered Person's funeral expenses upon receipt of a written request for reimbursement along with written evidence of actual payment of the funeral expenses.

Accidental Death, Dismemberment and Loss of Sight Benefits

If an Eligible Employee loses his or her life as a result of an occupational or non-occupational accident while a Covered Person, the Accidental Death benefit described below will be paid in addition to any other Death Benefit that may be payable pursuant to the Fund. No benefit will be paid unless the Covered Person is insured at the time of the accident for which benefits are claimed.

The Trustees have the sole discretion to determine whether a loss has resulted from an "accident" within the meaning of this section. No benefit will be paid for any loss occasioned by war or any act of war.

In the event that an Accidental Death of an Eligible Employee is caused by the Eligible Employee's driving while intoxicated, driving under the influence of drugs, commission of a suicide or the commission of Criminal Activities (as that term is defined in the General Health Care Coverage Exclusions section of this SPD), the Eligible Employee will not be entitled to the Accidental Death benefit described herein above but only to benefits described under the section entitled "Death Benefits."

If an Eligible Employee suffers an Accidental Death or any of the following Injuries within 90 days following the date of an occupational or non-occupational accident and such Injury results directly, independently and exclusively by reason of the accident, one and only one of the following benefits will be paid:

• Accidental Death	$15,000
• Loss of Both Hands	$15,000
• Loss of Both Feet	$15,000
• Loss of Sight of Both Eyes	$15,000
• Loss of One Hand AND One Foot	$15,000
• Loss of One Hand AND Sight in One Eye	$15,000
• Loss of One Hand	$7,500
• Loss of One Foot	$7,500
• Loss of Sight in One Eye	$7,500

Any benefit will be paid to the Eligible Employee, if living. If the Eligible Employee loses his or her life, then the Accidental Death benefit will be paid to his or her designated beneficiary.

Disability Benefits

Your weekly Disability benefit will be paid to you for Disability if you are unable to work due to either:

- Non-occupational accident; or
- Any Sickness for which you are attended by a Physician or other health care provider and for which you are not entitled to benefits under any Worker's Compensation law.

Benefits are payable for not more than 26 weeks of any one period of Total Disability on account of bodily Injury or disease. In order to apply for benefits, you must complete a Notice and Proof of Claim for Disability Benefits claim form, which must be submitted along with the attending Physician's/health care provider's statement to The Hartford (the Fund's Disability insurance provider) at the following address:

The Hartford Insurance Company
Disability Claims Department
P.O. Box 14303
Lexington, KY 45012-4303
Telephone: 800-538-8439
Fax: 877-431-8901.

The form must be submitted to the Hartford within 30 days of the date your Disability began.

Please contact the Fund Office to obtain a claim form.

The weekly Disability benefits through the Fund are subject to the regulations of the:

- New Jersey Temporary Disability Benefits Law, for all New Jersey employees;
- New York Disability Benefits Law, for all New York employees.

General Health Care Coverage Exclusions

The Trustees expressly retain, and will have, full discretion to resolve any issues of fact arising under the terms of the Plans and programs described in this document including, but not limited to, the right to make any and all final determinations of eligibility for benefits, the amount of reimbursement or payments to be made, the services or treatments for which coverage will be provided, and to resolve any questions of interpretation of the terms of any Plan or program described in this document.

Nothing in this document allows, nor will anything contained in this document be considered to allow, reimbursement of any expense for any treatment, drug or procedure that is deemed by the Trustees to be Experimental, Investigational, Custodial, Palliative or not Medically Necessary, as those terms are defined in this document or for any treatment, drug or procedure otherwise excluded by the Plan.

The following exclusions apply, and no benefits will be payable under any of the Plans or programs described in this document if any of the conditions described below apply.

Accidental Injuries and "No-Fault" Auto Insurance

The Fund limits services or treatments for Injuries resulting from motor vehicles, including motorcycles or other motorized transportation devices, that are subject to a state mandatory insurance laws. If some or all of the expenses incurred for the treatment of Injuries resulting from a motor vehicle accident are eligible for payment under the Personal Injury Protection or compulsory medical payments provisions of a motor vehicle insurance contract or under similar provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law, those expenses may not be covered by the Fund.

To obtain protection from the Fund, you must elect the best medical protection permitted under your state's auto insurance coverage rules and you must elect that the automobile insurance coverage be the primary plan to cover Injuries. The Fund will be "secondary" for Medical/Hospital expenses relating to an automobile accident. Your no-fault insurance is and will continue to be the primary carrier.

Regardless of what election you make, the Fund will only pay Medical/Hospital expense over the maximum available coverage afforded in each state, whether or not you have chosen the best coverage offered.

The Fund does not pay until you have exhausted your no-fault insurance coverage.

Administration for Vaccines and Immunization

Services for administration of vaccines, immunization or any preventive injections.

Clinic Maintained by an Employer, Union or Health Fund

Services received through a medical department clinic or similar Facility maintained by an employer, labor union or health fund.

Cosmetic Surgery

Any surgery, service, drug or supply designed to improve or preserve physical appearance of an individual but not physical function, is NOT covered under the Fund, except when surgery is necessitated by trauma, infection or other diseases; or when necessary to correct a congenital abnormality in a Covered Dependent Child which has resulted in a functional defect.

The Fund does cover reconstructive surgery in connection with a mastectomy.

Court-Ordered Services

Expenses for parental custody services and adoption services or court-ordered services unless the service is both Medically Necessary and covered by Plan.

Criminal Activities

Any Death or Injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, or any Death or Injury resulting from a Covered Person being involved in illegal activities, EXCEPT there will be no such exclusion for Death or Injury by reason of the illegal operation of a motor vehicle associated with alcohol or drug use.

Custodial Care

Expenses for Custodial Care, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, except when Custodial Care is expressly provided in this document, as, for example, in the case of certain Hospice Care.

Services required to be performed by Physicians, nurses or other skilled health care providers are not considered to be providing for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, nurse or other skilled health care provider are not covered, even if they are Medically Necessary.

Dental Care

Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion will not be covered under the Major Medical Plan for medical expenses except for treatment of a non-occupational Accidental Injury to the jaw or to natural teeth, including the initial replacement of such teeth and any necessary dental X-rays, provided any such services are rendered when the individual is covered under the Fund for no less than six months before the accident.

Education Services

Even if they are required because of an Injury, Illness or Disability of a Covered Person, the following expenses are not payable by the Plan: educational services, educational type supplies or equipment, including, but not limited to, computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a Patient or family members, and implantable medical identification/tracking devices.

Expenses Exceeding Maximum Plan Benefits

Expenses that exceed any Plan benefit limitation or maximum plan benefit as described in this document.

Expenses for:

- Biofeedback (a technique to teach a person to use signals from their body to reduce tension/anxiety);
- Hypnosis/hypnotherapy (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness);
- Equine (horse) assisted therapy;
- Services related to reading and learning disorders, dyslexia, educational delays, or vocational disabilities;
- Applied Behavioral Analysis (ABA) Therapy.

Expenses Incurred Before or After Coverage

Expenses for services rendered or supplies provided before the Patient became covered under the Plan or after the date the Patient's coverage ends, except under those conditions described in this document.

"Experimental" or "Investigational"

Expenses for services or supplies that are considered Experimental or Investigational. Please refer to the Empire Hospital benefits section for a definition of Experimental or Investigational.

Excess Charges

Charges in excess of the Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee as defined in the Definition Section of this document or in excess of the negotiated amount of any Third-Party Suppliers such as Empire BlueCross BlueShield, MagnaCare or S.I.D.S. MetroDENT.

Foot Care

There is no allowance for a Doctor's fee for care of the feet in a Hospital unless associated with the treatment of the Injury or condition for which Hospitalization was required. Expenses for routine foot care are not covered except for removal or reduction of corns and callouses and removal of thick/cracked skin on heels.

Forms Completion

Charges made for the completion of claim forms, medical/dental records/reports, bills, Disability/sick leave claims/forms and similar type of services; or for providing supplemental information; mailing, shipping or handling expenses; telephone calls; provider administrative fees; photocopying fees.

Government-Operated Facilities

Services furnished to the Covered Person in any veteran's Hospital, military Hospital, institution or Facility operated by the United States government (except for treatment of non-service related disabilities), or by any state government or any agency or instrumentality of such government, for which the Covered Person has no legal obligation to pay, as well as services or supplies for which a Covered Person is entitled (or could have been entitled upon proper application) to reimbursement by any plan, authority or law of any government or governmental agency (federal, state, dominion, province or any political subdivision thereof).

Internet/Virtual Office/Telemedicine Services

Expenses related to an online internet consultation with Physician or other health care practitioner, also called a virtual office visit/consultation, web visit, Physician-Patient web service or Physician-Patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.

Late-Filed Claims

Claims which are not filed with the Fund for handling within 12 months after the date the expenses are incurred, or six months for claims filed with Empire are not Covered by the Fund except in the absence of legal capacity of the Claimant.

Medical Students or Interns

Expenses for the services of a medical student or intern.

Military Service

Charges for treatment of any Injury sustained or Sickness contracted when in the military service of any country are not covered by the Fund, except as provided by law.

Missed Appointments

Expenses incurred for failure to keep a scheduled appointment.

Modifications of Homes or Vehicles

Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or Disability of a Covered Person, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

No Charge/No Legal Requirement to Pay

Services for which no charge is made or for which a Covered Person is not required to pay, or a charge that is not billed or would not have been billed in the absence of coverage under the Fund.

This exclusion does not apply to benefits or coverages which are available through the Medical Assistance Act (Medicaid).

Non-Eligible Services or Supplies

Any services, care or supplies not specifically listed in this document as Eligible Medical Expenses are NOT covered by the Fund. In addition to all other services stated in this Booklet as not covered, there is no allowance for surgical supplies, prosthetic devices, appliance repairs to any prosthetic devices or appliances, except as otherwise described in this Booklet.

Not Medically Necessary Services or Drugs

Any services, care, drugs or supplies deemed by the Trustees in their sole discretion to be not Medically Necessary.

Outside United States

Charges incurred outside of the United States if the Covered Person traveled to such a location for the purpose of obtaining such services, drugs or supplies are not Covered by the Fund. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment of a medical emergency.

Personal Comfort Items

Expenses for Patient convenience, including, but not limited to, care of family members while the Covered Person is confined to a Hospital or other health care Facility or to bed at home, guest meals, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, or private room (unless Medically Necessary), etc.

Services Not Prescribed by a Physician

Expenses for services/supplies that are not recommended or prescribed by a Physician, except for those covered services provided by a behavioral health practitioner, licensed midwife, certified nurse midwife, nurse practitioner, physician assistant, chiropractor, Dentist, acupuncturist, certified surgical assistant, or podiatrist.

Stand-by Physicians

Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the Patient, even if the Physician or health care practitioner was available to do so on a stand-by basis.

Telephone Calls

Expenses for any and all telephone calls between a Physician or other health care provider and any Patient, other health care provider, Medical Management, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or MedReview Medical Management for any purpose related to the care or treatment of a Covered Person, consultation with any health care provider regarding medical management or care of a Patient; coordinating medical management of a new or established Patient; coordinating services of several different health professionals working on different aspects of a Patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established Patient; providing counseling to anxious or distraught Patients or family members.

Temporomandibular Joint Problems

Treatment of temporomandibular problems.

Third-Party Liabilities

Any expenses caused by any third party when payment for such expenses has been paid (or will be paid or is required to be paid) by the third party or the third party's insurance company are not Covered by the Fund. See the definition of Subrogation and the section titled "Subrogation" for further information.

Travel

Expenses for or related to travel or transport (except as provided for emergency transport), whether or not recommended by a Physician.

War

Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from are not covered by the Fund, except as required by law.

Work-Related Conditions

Any condition for which the Covered Person has or had a right to compensation under any Worker's Compensation or occupational disease law or any other legislation of similar purpose.

All expenses arising from or sustained in the course of any occupation or employment for compensation, profit or gain.

Claims Procedures

General Claims Information

All benefits are considered for payment upon receipt of a written proof of a claim. A completed claim form usually contains the necessary proof of claim, but sometimes additional information or records may be required. You must comply with all reasonable requests for information in order to complete the review process and/or receive payment of benefits. Your failure to cooperate could result in your loss of the right to pursue your claim.

Pre-Service Claims (Including Urgent and Concurrent Claims)

Pre-Service claims for Durable Medical Equipment and IV Therapy should be sent to the Fund Office at the address below.

All other Pre-Service claims should be sent to MedReview. See the "Medical Management Program Section" for details on the procedures and what services and supplies require pre-certification.

Medical Benefits

All claims must be filed within 12 months after the date of service. Out-of-Network providers cannot be reimbursed directly. You are responsible to pay the provider and reimbursement will be made to you.

Post Service Claims

MagnaCare PPO In-Network Providers

There are no claim forms to file. The MagnaCare Physician will file all the required forms. All you need to do is present your insurance identification card with the MagnaCare insignia to the Physician and pay your copayment at the time of the visit.

Out-of-Network Providers

A supply of claim forms will be sent to each new Eligible Employee. Additional claim forms are available through the Fund Office. Fill out your portion of the claim form and mail it to the Fund Office at:

Local 807 Labor-Management Health Fund
32-43 49th Street
Long Island City, New York 11103
Telephone: 718-274-5353
Fax: 718-728-4413.

When you need to submit a claim to the Fund Office:

- Obtain a claim form from the Fund Office and complete the employee's portion of the claim form (including your name and Social Security number, the Patient's name and the Patient's date of birth);
- Have your Physician either complete the Attending Physician's Statement section of the claim form (including Date of Service, CPT-4 code or ADA codes, ICD-9 (the diagnosis code), Billed charge, Number of Units (for anesthesia and certain other claims), Federal taxpayer identification number (TIN) of the provider, billing name and address and, if treatment is due to accident, accident details **or** submit a completed universal (CMS-1500) health insurance claim form or have your provider submit a HIPAA-compliant electronic claims submission;
- Attach all itemized bills that describe the services rendered;
- Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result;
- Mail any further bills or statements for services covered by the Plan to the applicable address as soon as you receive them.

Death Benefit claims should also be filed with the Fund Office at the above address.

Post-Service Empire BlueCross BlueShield Hospital Claims

When you receive care from Facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received if you have a medical emergency out of the Empire service area. To obtain a claim form, call Empire's customer service. At some out-of-area and non-participating Hospitals, you may have to pay the Hospital's bill. If this happens, include an original itemized Hospital bill with your claim.

Send completed forms to:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional Claims Department.

You must file claims within six months of the date of service. Visit **www.empireblue.com** to print out a claim form immediately or contact Member Services at 800-553-9603 to have one mailed to you. Complete all of the information requested on the claim form and attach original bills or receipts. Photocopies will not be accepted. If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill. Keep a copy of your claim form and all attachments for your records.

S.I.D.S. Metrodent Dental Plan

Post-Service Claims

In-Network Dental Claim

There is no claim form required. In-Network Dentists will handle all the necessary paperwork and submit claims on your behalf.

Out-of-Network Dental Claim

Claim forms are available from the Fund Office or S.I.D.S. After dental work is performed, have your Dentist complete all items in the Dentist Information portion of the claim form and list the procedures, dates of services and charges and sign in the space provided for Dentist signature. You should then complete all items in the Member Information portion. Be sure to include Spouse and Dependent information. Completed claim forms, with X-rays and other attachments, should be sent to S.I.D.S. at the address below.

Out-of-Network providers cannot be reimbursed directly. You are responsible for paying the Dentist and reimbursement will be made to you.

Contact Information for S.I.D.S. Metrodent:

Self-Insured Dental Services
Dept. 75
P.O. Box 9005
Lynbrook, NY 11563-9005
Telephone: 800-537-1238 or 718-204-7172.

Optical Benefits

Post-Service Claims

In-Network Claim

There is no claim form required. In-Network vision care is provided by the DavisVision network of providers. To obtain a listing of network providers, please call 800-999-5431 and an interactive voice response unit will supply you with the names and addresses of providers nearest you. You may also access their website at **www.davisvision.com** and utilize the "find a doctor" feature.

Out-of-Network Claim

If you select an Out-of-Network provider, you must obtain a direct reimbursement form from the Fund Office. You pay the provider directly for all charges. You will be reimbursed up to the scheduled limit. To obtain the reimbursement, fill out the applicable sections and submit the completed form to the Fund Office with an itemized bill.

Prescription Drug Plan

You do not need claim forms when visiting an Express Scripts pharmacy. Simply present your card and your prescription to the pharmacist. In order to receive a claim form to fill your prescription through the Express Scripts Mail Order Program, contact Express Scripts. If you have any questions or need a list of Express Scripts In-Network pharmacies, call or email Express Scripts at:

Express Scripts, Inc.
Telephone: 800-711-0917
www.express-scripts.com.

Each time you place an order with Express Scripts, a new claim form will be included with your shipment.

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 in writing. 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 in the next section) without you having to complete the special authorization form.

Types of Claims

The claims procedures for filing claims for benefits as described above will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Disability Claim. Read each section carefully to determine which procedure is applicable to your request for benefits.

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care or services are provided. Under this Plan, prior approval of services is required for those services identified in the MedReview Medical Management Program section. See that section for a description of how to file a Pre-Service Claim.

Important: If you fail to pre-certify these services, the applicable penalties will be applied.

For properly filed Pre-Service Claims, you and/or your doctor will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of MedReview. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you do not submit your request for pre-certification directly to MedReview, such a submission will not constitute a claim. If there are problems with the filing of your Pre-Service Claim, MedReview will notify you as soon as possible, but not later than five days after receipt of the claim, of how to perfect the filing of the claim. You will only receive notice of an improperly filed Pre-Service Claim if the claim includes: (i) your name; (ii) your specific medical condition or symptom; and (iii) a specific treatment, service or product for which approval is requested. If you fail to notify MedReview within the required timeframes, your claim will not be considered to have been properly filed and the applicable penalties will apply.

If an extension is needed because MedReview needs additional information from you, the extension notice will specify the information needed. In that case you and/or your Doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). MedReview then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

Urgent Care Claims

An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service claim determinations:

- Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or
- In the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by MedReview by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine standard. Whether this standard is met is determined by appropriate clinical personnel. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, will be treated as an Urgent Care Claim.

If there is a problem with the filing of your Urgent Care Claim, MedReview will notify you as soon as possible but not later than 24 hours after receipt of the claim of the proper procedures to be followed in filing a claim. Unless the claim is filed properly, it will not constitute a claim. If you fail to notify MedReview within the required timeframes, your claim will not be considered to have been properly filed and the applicable penalties will apply.

If you are requesting pre-certification of an Urgent Care Claim, the time deadlines are different. MedReview will respond to you and/or your Doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by MedReview. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, MedReview will notify you and/or your Doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your Doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided to you no later than 24 hours after MedReview receives the specified information if the delay for additional information extends beyond 72 hours from the receipt of the claim.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an Inpatient Hospital stay originally certified for two days that is reviewed at three days to determine if additional days are necessary and appropriate.) In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

If the circumstances of the claim change, a reconsideration of the benefits with respect to the claim will be made by MedReview as soon as possible. This reconsideration will be made early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a Claimant to extend approved Urgent Care treatment will be acted upon by MedReview within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A Pre Service request to extend approved treatment that does not involve Urgent Care will be decided within 48 hours. A Post Service request to extend approved treatment will be decided within the post-service timeframes explained below.

Post-Service Claim

A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

Ordinarily, you will be notified of the decision on your Post-Service claim within 30 days from the organization responsible for paying the claim after receipt of the claim. This period may be extended one time by the applicable organization for up to 15 days if the extension is necessary due to matters beyond the control of the organization. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

If an extension is needed because the organization needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The organization responsible for paying the claim will then have 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Disability Claims

For Disability Claims, the Hartford Insurance Company will make a decision on the claim and notify you of the decision within 45 days.

If you disagree with Hartford's decision on your claim, you have the right to appeal. See Section below entitled Request for Review of Denied Claim.

If you live in **New York**, you should complete the reverse side of the Notice of Rejection sent by The Hartford and mail it within 26 weeks to the Disability Benefits Bureau at:

Disability Benefits Bureau
Worker's Compensation Board
100 Broadway-Menands
Albany, NY 12241.

If you live in **New Jersey**, your written appeal should be sent to the Division of Temporary Disability Insurance, within one year from the date your Disability began, at:

Division of Temporary Disability Insurance
Private Plan Operations
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625-0957.

Death and AD&D Claims

A Death Benefit claim is a claim for benefits under the Plan. The Plan conditions availability of the benefit on proof of death.

A decision will be made within 60 days of your claim for the Death Benefit. An extension of the 60 days may be granted for reasons beyond the control of the Health Fund. You will be advised in writing within the 60 days after receipt of your claim if an additional period of time will be necessary to reach a final decision on your AD&D or death claims.

Notice of Decision for Claims

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

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on a review;

- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive a statement that the rule is available upon request at no charge;
- If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive a statement that the explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge;
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and confirmed with written notification.

For Urgent Care Claims and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. You must submit your appeal request within 180 days of your receipt of the denial.

Your request for review must be made in writing to the applicable organization as noted below.

All Appeals that Involve Pre-Service, Concurrent and Urgent Care Appeals

Appeals involving Pre-Service, Concurrent or Urgent Care Claims may be made orally by calling the MedReview Medical Management Program at 800-688-2284.

MedReview Medical Management Program
190 Water Street
27th Floor
New York, NY 10038

Post-Service Hospital Appeals

First Level Appeals for Post-Service Hospital claims must be submitted directly to the Medical Management Program at:

MedReview Medical Management Program
190 Water Street
27th Floor
New York, NY 10038
Telephone: 800-688-2284.

If you are dissatisfied with the outcome of your first appeal, you may file a second level appeal with Empire within 60 calendar days from the date on the notice denying your first appeal. A second appeal is available for post-service Hospital claims. These requests should be sent to:

Empire Blue Cross
P.O. Box 1407
New York, NY 10048
Telephone: 800-553-9603.

All Other Appeals (For Medical (including non-Empire Alcohol, Substance Abuse and Mental Health), Optical, Death, Dental and Prescription Drug Benefits and Pre-Service IV Therapy and Durable Medical Equipment Claims)

All other appeals should be submitted in writing to the Board of Trustees at:

Board of Trustees of the Local 807 Labor-Management Health Fund
32-43 49th Street
Long Island City, NY 11103
Attn: Fund Manager.

Appeals must be submitted in writing to the appropriate organization within 180 days after you receive notice of denial.

Review Process for Claims

A. Submit Appeal within 180 Days

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon);it demonstrates compliance with the administrative processes for ensuring consistent decision making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, whogave advice to the organization responsible for the initial determination of your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your appeal than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

B. Timing of Notice of Decision on Appeal

Pre-Service Claims

You will be sent a notice of decision on review within 15 days of receipt of the appeal by MedReview.

If you are dissatisfied with the outcome of your first appeal, you may file another appeal with MedReview within 180 calendar days from the date on the notice of the letter denying your first appeal. You will be sent a notice of decision on review of your second appeal within 15 business days from MedReview's receipt of the second appeal.

For pre-service IV Therapy and Durable Medical claims, you will be sent a notice of decision on review within 30 days of the appeal by the Board of Trustees.

Urgent Care Claims

You will be sent a notice of a decision on review within 72 hours of receipt of the appeal by MedReview.

Post-Service Hospital Claims

There is a two level review for post-service Hospital claims. You will be sent a notice of a decision by MedReview within 30 days for the first level of appeal.

If you are dissatisfied with the outcome of your first appeal, you may file another appeal with Empire within 60 calendar days from the date on the notice denying your first appeal. You will be sent a notice of decision on review of your second appeal within 30 business days from Empire's receipt of the second appeal.

All Other Post-Service Claims—All Non-Hospital Appeals—Appeals for Medical (including non-Empire Alcohol and Substance Abuse and Mental Health), Optical, Prescription Drug, Dental, Life and AD&D Benefits

Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

C. Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- A statement that if an internal rule, guideline or protocol was relied upon by the Plan, it is available upon request at no charge;
- If the determination was based on lack of Medical Necessity, or because the treatment was Experimental or Investigational, or other exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, is available upon request at no charge.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have exhausted all of your administrative remedies under the Plan, meaning until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) without exhausting these appeal procedures if the Plan has failed to follow those procedures. **No lawsuit may be started more than three years after the end of the year in which medical or dental services were provided, or, if the claim is for short-term Disability benefits, more than three years after the start of the Disability.**

Coordination of Benefits (COB)

Coordination with Other Employer Plans or Private Insurance

Many families with more than one person working are covered by more than one medical or dental plan. If you or your Spouse or your Dependent is eligible for benefits from any other group health plan, then the Fund will "coordinate" the benefits it pays to assure that the total benefits paid will not exceed the charges incurred. Further, a special set of rules will be applied to determine which plan has the primary responsibility to pay.

These rules will be applied under the general rule requiring that an employed Spouse must elect coverage in the best available plan offered by their current employer regardless of any cost associated with that coverage. If the Spouse does not elect the best available coverage in their employer's plan, these rules will be applied under the assumption that such coverage was elected.

Coordination of Benefits operates so that one of the plans (called the primary plan) will pay claims first. The other plan (called the secondary plan) may then pay additional benefits not paid by the primary plan. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

If Your Spouse Has Coverage Available Through His or Her Employer

The Fund requires that all Spouses elect coverage offered by their employer. For persons who first become Participants on or after April 1, 2003, or for any Participant whose Spouse commences or begins a new job on or after April 1, 2003, the Spouse is required to elect the most complete hospitalization, medical, prescription drug, dental and/or vision coverage available through his or her employer regardless of any associated cost. If your Spouse declines this coverage, the Fund will still treat him or her as covered under the most comprehensive coverage offered by his or her employer.

However, if a Spouse loses coverage under an employer's plan, constituting an event which is a "Qualifying Event" for purposes of coverage under COBRA, the Spouse will not be required to elect COBRA coverage in order to qualify for coverage under the Fund, provided that the Spouse will again be required to elect to participate in his or her employer's plan as of the earliest date such election becomes again available to him/her.

If your Spouse has coverage other than COBRA coverage through his or her employer, the Fund will be the secondary payer for any claims incurred by your Spouse and, as the secondary payer, will only reimburse covered expenses to the extent those expenses would not have been reimbursed under your Spouse's best available coverage. This reduction in coverage will be applied whether or not your Spouse has actually enrolled in that best coverage.

Benefits from the Fund will always be secondary for a Spouse who could elect coverage through his or her employer. In addition, if any of your Dependent Children could be covered by your Spouse's coverage, they will be treated as if covered, regardless of whether they are, in fact, covered by your Spouse's plan. In this situation, the Fund will pay benefits as if your Dependent Children are covered by both plans, in accordance with Coordination of Benefit rules described below.

Which Fund Pays First: Order of Benefit Determination Rules

The plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific order. The Fund uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.

If the first rule does not establish a sequence or order of benefits, the next rule applies, and so on, until an order of benefit payment is established. The rules are:

Rule 1: Non-Dependent/Dependent

1. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a Spouse or Dependent) pays first.
2. The plan that covers the same person as a Dependent pays second.
3. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is:
    a. Secondary to the plan covering the person as a Dependent; and
    b. Primary to the plan covering the person as other than a Dependent (that is, the plan covering the person as a retired employee);
    c. Then the order of benefits is reversed, so that the plan covering the person as a Dependent pays first; the plan covering the person other than as a Dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

1. The plan that covers the parent (or would have covered the parent if he or she was enrolled in his or her employer's plan) whose birthday falls earlier in the year pays first; the plan that covers the parent whose birthday falls later in the year pays second, if:
    a. The parents are married;
    b. The parents live together (regardless of whether they have been married); or
    c. A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

2. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; the plan that has covered the other parent for the shorter period of time pays second.

3. The word "birthday" refers only to the month and day in a Calendar Year, not the year in which the person was born.

4. If the specific terms of a court decree state that one of the parents is responsible for a 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 Fund had actual knowledge of the specific terms of that court decree.

5. If the parents are not married, or do not live together (regardless of whether they were married), or are divorced, and there is no court decree allocating responsibility for a child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:

    a. The plan of the custodial parent pays first;

    b. The plan of the current Spouse of the custodial parent pays second;

    c. The plan of the non-custodial parent pays third; and

    d. The plan of the current Spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

1. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's Dependent, pays first; and the plan that covers the same active person as a laid-off or retired employee, or as that laid-off or retired employee's Dependent, pays second.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. If a person is covered as a laid-off or retired employee under one plan and as a Dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

1. 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 an employee, retiree, member or subscriber (or as that person's Dependent) pays first, and the plan providing continuation coverage to that same person pays second.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. If a person is covered other than as a Dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a Dependent of an active employee under another plan, the order of benefits is determined by the rule in (1) above rather than by the rule in (2) above.

Rule 5: Longer/Shorter Length of Coverage

1. 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.
2. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
3. The start of a new plan does not include a change:
    a. In the amount or scope of a plan's benefits; or
    b. In the entity that pays, provides or administers the plan; or
    c. From one type of plan to another (such as from a single employer plan to a multiple employer plan).
4. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Coordination of Benefits with Government Programs and Coverages Provided by Law

Coordination of Benefits with Medicare

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. Any employee or Spouse near the age of 65 should file for Medicare coverage in order to avoid a delay in the commencement of Medicare coverage and to avoid additional premium payments under Part B of Medicare when you finally do apply. If you do not sign up for Medicare when you are first eligible, there may be a waiting period for benefits after you do sign up.

Active Employees Over Age 65

If you continue to work for a Contributing Employer after you reach age 65 and are eligible for Medicare, you are entitled to the same benefits as Employees under age 65 as long as you meet the regular eligibility requirements. This Plan will be your primary provider of health care benefits. Medicare will pay secondary only for covered expenses that the Plan does not

pay. You may decline coverage under this Plan. If you do, Medicare will be your only health care coverage.

If you prefer Medicare as your health care coverage when you are age 65, contact the Fund Office. Unless you make this choice, the Plan will continue to pay primary benefits for you as long as you remain eligible.

Medicare Disability Coverage

If you are still actively working and you or a Dependent becomes entitled to Medicare because of Disability, the Fund will be primary and Medicare will be secondary.

Medicare and COBRA

If you are age 65 or over OR are disabled and covered by both Medicare and COBRA Continuation Coverage, Medicare pays first and this Plan pays second.

However, if you are entitled to Medicare because of End-Stage Renal Disease (ESRD) and covered under COBRA Continuation Coverage, coordination works in the same way as it does for an active participant (as described below).

End-Stage Renal Disease

If, while you are actively employed, you or any of your Covered Dependents becomes entitled to Medicare because of end-stage renal disease (ESRD), the Fund pays first and Medicare pays second for the effected Covered Person for a limited period of time.

Medicare imposes a three-month waiting period at the onset of end stage renal disease before Medicare becomes effective. Medicare waives this waiting period if the Patient enrolls in a self-dialysis training program within the first three months of the diagnosis of ESRD or receives a kidney transplant within the first three months of being Hospitalized for the transplant.

If there is a waiting period, the Fund continues to be the primary payer for the three-month waiting period. The Fund will then be the primary payer for the next 30 months. Medicare becomes the primary payer after the 30 month period.

Coordination of Benefits with Medicaid

If you are covered by both the Fund and Medicaid, the Fund pays first and Medicaid pays second.

Coordination of Benefits with TRICARE

If you are covered by both the Fund and TRICARE, the Fund pays first and TRICARE pays second.

Other Coverage Provided by State or Federal Law

If you are covered by both the Fund and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and the Fund pays second, unless otherwise provided by applicable law.

How Much the Fund Pays When it is Secondary

When the Fund pays second, it will pay no more than 100% of reimbursement that would be payable by the Fund if it was the primary payer, less whatever payments were actually made by the other plan or plans that paid first.

An expense or service, or any portion of an expense or service, that is not normally covered by the Fund will not become reimbursable simply because it may have been covered by one of the other plans.

If benefits are reduced by a primary plan because a Covered Person did not comply with the primary plan's provisions, such as the provisions related to the Medical Management Program utilized by the Fund, the amount of those reductions will not be reimbursable by the Fund when it pays second.

Administration of COB

To administer COB, the Plan reserves the right to: exchange information with other plans involved in paying claims; require that you or your health care provider furnish any necessary information; reimburse any plan that made payments this Plan should have made; or recover any overpayment from your health care provider, you or your Dependent for payment that should not have been made.

If this Plan pays benefits that were also paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan's Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, this Plan will not pay any benefits.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position.

Rights of Subrogation, Reimbursement and Recovery

Benefits Subject to this Section

These rules ensure that benefits will be paid properly. These rules will apply to all benefits provided by the Fund. **As a condition to receiving benefits from the Fund, the Covered Person agrees that acceptance of benefits from the Fund is constructive notice of these provisions.**

When this Section Applies

A Covered Person may incur medical or other expenses related to Injuries or Illness caused by the act or omission of another person; or another party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or another party for payment of the medical or other charges.

The Fund does not provide coverage for any expenses related to an Illness or Injury to the extent that the Covered Person receives any money from or on behalf of a Third Party who was responsible for that Illness or Injury. Thus, any money that a Covered Person receives from a responsible third party, regardless of how that payment is characterized, reduces the amount of benefits that the Fund will pay on a dollar for dollar basis. However, as a courtesy to its Covered Persons, the Fund will advance payment of benefits on account (hereafter called an "Advance"), subject to its rights to recover and be reimbursed to the full extent of any Advance payment from the Covered Person if and when there is any recovery from any third party.

The Fund's Rights Explained

The Fund's Right of Subrogation

The Fund's has the right to pursue the Covered Person's claims for medical and other charges paid by the Fund against another party.

The Fund's Right of Recovery

The Fund has the right to recover any and all monies paid to or recovered by the Covered Person by way of judgment, settlement, or otherwise to compensate for any losses caused by, or in connection with, the Injuries or Illness, regardless of how such recovery is characterized.

The Fund's Right of Reimbursement

The Fund has the right to repayment for medical or other benefits that it has paid or advanced toward care and treatment of an Injury or Illness of a Covered Person and for all of the expenses incurred by the Fund in collecting this benefit amount.

The Fund will have a first priority equitable lien against any recovery received by the Covered Person to the extent of benefits paid by the Fund under this section and regardless of whether the Covered Person is made whole for his or her Injuries. The Fund will automatically have this lien to the extent of the Advance, upon any recovery, (whether by settlement, judgment or otherwise), by the Covered Employee and/or Covered Dependent. The Fund's lien extends to any recovery from a third party, a third party's insurer, and/or a third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Fund's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

By accepting an Advance, the Covered Person agrees that the Fund will be subrogated to the Covered Person's right of recovery from a third party or that third party's insurer for the entire amount advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the Injury or Illness that resulted in the Advance, the Plan may be substituted in place of the Covered Employee and/or Covered Dependent(s), but only to the extent of the amount of the Advance. The Fund is subrogated in any and all actions against third parties for the portion of all recoveries to which the Fund is entitled.

Under its Subrogation rights, the Fund may, at its discretion: start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the Covered Person, but in doing so, the Plan will not represent, or provide legal representation for the Covered Person with respect to his or her damages that exceed any Advance; or intervene in any claim, legal action, or administrative proceeding started by the Covered Person against any third party or third party's insurer concerning the Injury or Illness that resulted in the Advance.

The Fund will hold a constructive trust with regard to that portion of the Covered Person's recovery that is the extent of the Advance. The Covered Person and those acting on his or her behalf, must place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Fund is satisfied. The location of the account and the account number must be provided to the Fund. In the event the Covered Person or any entity acting on his or her behalf fail to maintain this segregated account or comply with any of the Fund's reimbursement requirements and/or provisions of this section, such individual or entity stipulates to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Fund receives all amounts that must be reimbursed.

The Fund's Rights will apply:

1. Even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and

2. Even if the recovery is not sufficient to make the ill or injured Covered Person whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. Without any reduction for legal or other expenses incurred by the Covered Person in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. Regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the Illness or Injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule); and
5. To any amount paid with respect to, associated with, or stemming from the Injuries incurred whether paid directly or indirectly to the Covered Person, or his or her Spouse, Dependents, beneficiaries, or estate; and
6. Even if the recovery was reduced due to the negligence of the Covered Person (sometimes referred to as "contributory negligence") or any other common law defense.

The Fund's rights will apply to any fund, account or other asset created:

- Pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Covered Person payable by any third party or his or her insurer on account of an Illness or Injury alleged to have been caused by that third party; or
- As a result of any settlement paid by any third party or his or her insurer on account of any claim by or on behalf of the ill or injured Covered Person.

Reimbursement and/or Subrogation Agreement

The Covered Person on whose behalf the Advance is made, must sign and deliver a reimbursement and/or Subrogation agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Fund. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor Dependent Child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Fund makes an Advance in the absence of an Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights.

Cooperation with The Fund by All Covered Persons

By accepting an Advance, regardless of whether or not an Agreement has been executed, the Covered Person agrees to:

1. Advise the Fund, within 10 calendar days after he or she has made a claim against a third party, or instituted legal action against a third party;

2. Assign a claim against a third party to the Fund when Subrogation is available, if the Fund so requests;
3. reimburse the Fund for all amounts paid or payable and/or that will become payable to the Covered Person from the third party or that third party's insurer for the entire amount advanced;
4. acknowledge, confirm and/or stipulate that the Fund has the first right of reimbursement from any judgment or settlement;
5. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Fund's rights;
6. not assign the right of recovery to any third party without the specific written consent of the Fund;
7. notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the Injury or Illness that resulted in the Advance, or entering into any settlement agreement with that third party or third party's insurer based on those acts;
8. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party, including settlement, judgment or payment, within 10 days of such development.

Failure to fully cooperate with the Fund and comply with the rules of this Section may result in the Fund not advancing any benefits towards the subject Illness or Injury.

Remedies Available to the Fund

In addition to the remedies discussed above, if the Covered Person does not reimburse the Fund's Advance as required by this provision, the Fund may, at its sole discretion:

1. Apply any future Plan benefits that may become payable on behalf of the Covered Person to the amount not reimbursed; or
2. Obtain a judgment against the Covered Person for the amount advanced and not reimbursed, and garnish or attach the wages or earnings of the Covered Person, or
3. Take any other action that the Trustees deem necessary and/or appropriate.

In addition to satisfaction of the existing assignment or liens from any recovery received by the Covered Person, the Fund is also entitled to a future credit for future related expenses equal to the net monies received by the Covered Person. As such, the Covered Person must spend a net recovery on related Fund expenses until the amount of said net recovery is exhausted. It is only at this point that the Covered Person's further related Fund benefits will again be the responsibility of the Fund pursuant to the terms of the Fund. The Fund Office will determine the net monies available for a future credit.

The Trustees, in their sole discretion, may require the Covered Person to assign his or her entire claim against a third party to the Fund. If the Fund recovers from a third party any amount received in excess of the benefits paid the Covered Person after reimbursing expenses incurred and making recovery, the difference will be paid to the Covered Person.

Continuation of Health Care Coverage (COBRA)

Introduction

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the health care coverage provided under this Plan and is available to you and your Eligible Dependents at your own expense provided your coverage is lost due to a "Qualifying Event."

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 active employee or Eligible Dependent who is covered by the Plan when a Qualifying Event occurs. A child who becomes an Eligible Dependent by birth, adoption, or placement for adoption with an active employee during a period of COBRA coverage is also a Qualified Beneficiary. A person who becomes your Spouse after the Qualifying Event occurs and during a period of COBRA coverage is not a Qualified Beneficiary.

If you choose COBRA coverage, you and your Dependents may continue the same medical, Hospital, dental, optical and prescription drug coverage that you had prior to the Qualifying Event. COBRA does not cover Death and AD&D Benefits or Disability benefits.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs than you would be responsible for under this Plan. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying Event	Employee	Dependent Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct)	18 months*	18 months*	18 months*
Employee reduction in hours worked (making employee ineligible for coverage)	18 months*	18 months*	18 months*
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Employee becomes entitled to Medicare**	N/A	36 months	36 months
Dependent Child ceases to have Dependent status	N/A	N/A	36 months

Notice that You or Your Dependent(s) are Entitled to Continuation Coverage

When the Fund is notified that your employment has been terminated or that your hours have been reduced so that you are no longer entitled to coverage under the Fund, or when your Dependents give the Fund timely notice that you died or you or your Dependents give notice, that you were divorced or legally separated, that you became entitled to Medicare, or that a Dependent Child lost Dependent status; then you, your Spouse and/or your Dependent(s) will be notified that you and/or each of them has the right to continue their health care coverage. **You and/or your Dependent(s) will then have 60 days ("60-day period") to apply for COBRA continuation coverage. If you and/or they do not apply within that time, their health care coverage will end as of the date of the Qualifying Event.**

* This initial eligibility period may be extended to 29 months if you are deemed to be eligible for Social Security Disability Benefits during the first 60 days of COBRA continuation coverage. See the "Entitlement To Social Security Disability Income Benefits" section for information on how to qualify for this extension.

** Special Rule For Medicare: When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee becomes entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until the later of 36 months after the date of Medicare entitlement or the period of coverage provided based on the Qualifying Event. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for his or her Spouse and Dependent Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

When Dependents Must Notify the Fund of a Qualifying Event

You, your Spouse or your Dependent Children must notify the Fund within 60 days of the later of the (1) Qualifying Event or (2) date that the Qualified Beneficiary would lose coverage after the Qualifying Event of:

- The death of the employee;
- The divorce or legal separation from the employee; or
- The event under which a Dependent Child loses Dependent status.

If the Fund does not receive written notice of that event within the 60-day period, the Spouse or Dependent may not be eligible for COBRA continuation coverage. However, you are ultimately responsible for notifying the Fund Office of the Qualifying Event according to the procedure described below if your Dependent Child wishes to elect COBRA continuation coverage. In order to provide the Fund with notice of any of the above situations, you must send a letter to the Fund Office containing the following information: your name, the events for which you are providing notice, the date of the event, the date on which the Spouse and/or Child(ren) will lose coverage, along with a copy of the supporting documentation (e.g., a copy of the first and last page (signature page) of the divorce decree or a copy of a child's birth certificate or other proof of age or death certificate). Notice must be sent to the Fund Office. If you notified the Fund Office of a Qualifying Event and you are not entitled to COBRA coverage, the Fund Office will send you a written notice stating the reason you are not eligible for COBRA. The Fund Office will provide this notice within 14 days after its receipt of your notice of a Qualifying Event.

Coverage that Will Be Provided if You Elect Continuation Coverage

If you and/or your Dependent(s) choose COBRA continuation coverage, the Fund will provide coverage that is identical to the then current coverage under the medical or dental plan that is provided for similarly situated employees or family members. The same rules about Dependent status and qualifying changes in family status that apply to active employees will apply to you and/or your Dependent(s).

Multiple Qualifying Events

If continuation coverage is limited to a maximum period of 18 months and if, during that 18 month period, another qualifying event occurs that would normally entitle a Spouse or Dependent to a 36-month period of continuation coverage, the 18-month period will be extended for that person. In no event will the total period of continuation coverage exceed 36 months from the date of the first Qualifying Event. You must notify the Plan in writing within 60 days of the later of: (1) the date of the relevant second Qualifying Event; or (2) the date coverage would be lost under the plan as a result of the Qualifying Event if you want to extend your continuation coverage. You must send a letter to the Fund containing the following information: your name, the event for which you are providing notice, and the date of the event along with a copy of the supporting documentation (e.g., a copy of the first and last page of the divorce decree, a copy of a child's birth certificate or other proof of age or a copy of the employee's death certificate).

If a former employee dies within 18 months after having left Covered Employment and having elected COBRA continuation coverage, the continuation coverage for the Spouse or Dependents may be extended until the last day of the 36th month period following the date the former employee's employment terminated.

Entitlement to Social Security Disability Income Benefits

If you, your Spouse or any of your Covered Dependents are entitled to continuation coverage for an 18-month period, that period can be extended for up to 11 additional months but only if:

- A Disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage;
- The disabled person receives a determination of entitlement to Social Security Disability Income Benefits from the Social Security Administration within the 18-month COBRA continuation period; and
- You or the disabled person notifies the Fund of such a determination within that 18-month period.

This extended period of COBRA continuation coverage will end at the earlier of the end of 29 months or when the disabled individual becomes entitled to Medicare.

What You Must Pay for COBRA Continuation Coverage

You and/or your Covered Dependent(s) will have to pay 102% of the full cost of the coverage during the COBRA continuation period. However, any individual who is entitled to Social Security Disability Income Benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA continuation coverage.

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full no later than45 days following the date of your election, you will lose all continuation coverage rights under the Plan.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent month. Under the Plan, each of these payments for continuation coverage is due on the first of the month for that month. If you make a payment on or before the first day of month for which it applies, your coverage under the Plan will continue for that month without any break. The Fund is not required to remind you that your monthly payments are due.

Grace Periods for Periodic Payments

Although payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the month to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that month. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the month) when the payment is received. This means that any claim you submit for payment while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose **all** rights to continuation coverage under the Plan.

Termination of COBRA Continuation Coverage

COBRA coverage ends when the COBRA period (18, 29, or 36 months as the case may be) ends. COBRA continuation coverage will be terminated earlier, if, after the date COBRA is elected:

- The Covered Person does not pay the applicable premium for his or her COBRA continuation coverage within 30 days of the date it is due; or
- The Covered Person becomes entitled to Medicare (after the COBRA election); or
- The Covered Person becomes covered under another group health plan (after the COBRA election); or
- The Fund no longer provides any medical or dental coverage to any Covered Persons; or
- In the case of an 11-month extension due to a Disability, it is determined by Social Security during the extension period that you are no longer disabled.

If any Covered Person becomes entitled to Medicare after qualifying for COBRA, the COBRA continuation coverage of that person ends, but the COBRA continuation coverage of any Covered Spouse or Dependent Child will not be affected.

If COBRA coverage is terminated as described above, the Fund Manager will send you a written notice as soon as practicable following his or her determination that COBRA coverage will terminate. The notice will set out why COBRA coverage will terminate early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Other Information

You do not have to prove that you or your Eligible Dependents are insurable to choose COBRA continuation coverage.

If the coverage provided by the Fund is changed in any respect for active Eligible Employees, those changes will apply at the same time and in the same manner for everyone whose coverage is continued pursuant to COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued pursuant to COBRA as of the effective date of those changes.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a Plan Sponsored by your Spouse's employer) within 30 days after your group health coverage ends with this Plan because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you receive continuation coverage for the maximum time available to you.

Other Coverage Options Besides COBRA 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." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.health care.gov**.

If You Have Questions

Questions concerning the Fund or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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.)

Keep Your Plan Informed of Address Changes

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, for your records, of any notices you send to the Fund Office.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Use and Disclosure of Protected Health Information

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), is a federal law which requires that health plans like the Local 807 Labor-Management Health Fund (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called "**Protected Health Information" or "PHI"**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by an Employer who participates in this Fund in its role as an Employer, including, but not limited to, health information on Disability, work-related Illness/Injury, sick leave, Family and Medical leave (FMLA), or drug testing.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Fund Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees of the Plan), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law.

The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. The Plan's use and disclosure of PHI

The Plan is not required to obtain your authorization or consent to use protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

1. **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. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

2. **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:

    a. 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 contribution rates for coverage;

    b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), Coordination of Benefits, Subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

    c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

3. **Health Care Operations** includes, but is not limited to:

    a. 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, Patient safety activities;

    b. 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;

    c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), 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;

    d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

    e. 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.

    f. 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;

    g. Modifying, amending or terminating the Plan.

B. When an Authorization Form is needed

Generally the Plan will require that you sign a valid authorization form (available from the Fund Office) in order for the Plan to 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 or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. Disclosure of PHI to the Plan Sponsor

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 their 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 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 employee 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 Dept. 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. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. Separations between Plan and the Plan Sponsor

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only Fund employees and those Business Associates, Agents and Subcontractors working on behalf of the Welfare Fund in the course of Plan Administration activities may be given access to use and disclose PHI. This access to and use of PHI will be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

"Plan administration functions" are activities that would meet the definition of payment, treatment or health care operations, as set forth above.

In the event any individual above does not comply with the provisions of HIPAA relating to use and disclosure of PHI, the Plan Administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Fund Office.

E. Effective April 21, 2006 in compliance with HIPAA Security regulations, the Plan Sponsor will:

1. 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;
2. Ensure that adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures;
3. Ensure 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
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

F. Hybrid Entity

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 group health plan functions are covered by the privacy rules. The group health plan functions include the self-funded medical, Hospital, prescription drug, dental and vision benefits, and eligibility and COBRA administration. The non-group health plan functions are not covered by the privacy rules and include death, AD&D and Disability benefits.

G. Your rights regarding your PHI

While the Fund is required to use PHI for some purposes permitted under HIPAA, you have the right to object to the use of your information, to gain access to your information, to offer changes to the information and to obtain an accounting of any information disclosures. Further, you may provide a written Authorization directing that your PHI be disclosed to any person or entity. The Fund requires that any such Authorization be in writing in a form acceptable to the Fund.

Each Covered Person will be asked to Consent, in writing, to the use of your PHI for certain purposes that will be described in the Consent form. Failure to provide a Consent will prohibit you from enrolling in the Fund or receiving benefits from the Fund. Your health care provider may also seek your Consent to the use of your PHI.

With some exceptions, you may request a copy of the PHI maintained by the Fund about you. The request must be in writing, in a form acceptable to the Fund, and be delivered to the Fund Office. The Fund will generally respond within 30 days of any such request for information readily available to it at the Fund Office, or within 60 days if the information is maintained off-site, with an extension of an additional 30 days if necessary. If the Fund needs the 30-day extension, you will be given a written notice of the extension.

The Fund may deny you access to some, or all of your PHI where a licensed health care professional has determined that access to this information may cause harm to you or another individual. If the Fund decides that certain information will not be provided to you, the Fund will give you written notice including an explanation of the reason for the refusal to provide the information. If the Fund denies you access for these reasons, you may ask the Fund to have the denial reviewed by a licensed health care professional who did not participate in the original decision to deny you a copy of your PHI. The Fund will inform you of the determination of the licensed health care professional who reviewed your request and act in accordance with his or her determination.

HIPAA Security Practices

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use electronic PHI for Plan administrative requirements (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the electronic PHI;
- Report to the Plan any incident of a breach of security incident of which it becomes aware ("Security Incident");
- Notify Participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with HIPAA's health breach notification rule (16 CFR Part 318); and
- Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with HIPAA's health breach notification rule (16 CFR Part 318).

Any terms not otherwise defined in this section will have the meanings set forth in the Security Standards.

Definitions

When used in this document, the following items will have the meanings shown below:

Accidental Death

Any death which results from Accidental Injury or by external forces under unexpected circumstances.

Accidental Injury

Any accidental bodily Injury which occurs when an individual is covered under the Fund and which is caused by external forces under unexpected circumstances and which does not arise out of or in the course of the employment of a Covered Person. Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Administrator or Plan Administrator

Board of Trustees of the Local 807 Labor-Management Health Fund.

Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee

Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. **With respect to an In-Network provider** (PPO network Health Care or Dental Care provider/Facility), the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/Facility and the PPO network or the Plan; or
2. **With respect to a Non-Network provider,** Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers.

The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), Reasonable and Customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

1. For an In-Network Health Care Provider/Facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including, but not limited to, auto insurance, Worker's Compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; or
2. The health care or dental care provider's/Facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the health care or dental care provider's actual charge for health care services or supplies, even after you have paid the applicable deductible, copay and/or coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's deductibles, annual coinsurance or out-of-pocket maximums. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan. This is also known as balance billing.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a utilization management company, claims administrator, attorney, stop loss carrier, medical claim-repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, In-Network/non-network plan design, and any special reimbursement provisions adopted by the Plan.

Alternate Recipient(s)

See QMSCO Section of this booklet.

Ambulatory Surgical Center

Any public or private establishment which complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located; with an organized medical staff of Physicians; with permanent Facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous Physician services and registered professional nursing services whenever a Patient is in the Facility; and which does not provide services or other accommodations for Patients to stay overnight.

Calendar Year

The period from January 1 of each year and through the next succeeding December 31.

Claimant

Any Covered Person who submits a claim for benefits.

Contribution Hours

Hours of work in Covered Employment for which Health Fund contributions are made on behalf of the employee.

Convalescent Hospital or Convalescent Care Facility

See "Skilled Nursing Facility."

Covered Dental Expenses

Dental Services provided for in the Schedule of Covered Expenses (available at the Fund Office), when the dental service is performed by or under the direction of a duly licensed Dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

Covered Employment

Work for an Employer who is required to contribute to the Fund and who has actually paid the required contributions on behalf of its Covered Employees.

Covered Person

A Covered Eligible Employee, a Covered Dependent, and/or a Qualified Beneficiary.

Custodial Care

Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping Patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given by people who are not trained or licensed medical or nursing personnel.

Dentist

A person holding a degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice Dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Dependent

See Eligibility section of this booklet.

Disability

See "Totally Disabled."

Eligibility Quarter

See Eligibility section of this booklet.

Eligible Employee

See Eligibility and Effective Dates sections of this Booklet.

Eligible Medical Expense

An expense which is: (1) covered in accordance with this document; (2) not services or supplies that are excluded from coverage or in excess of any Plan maximums or limitations; (3) for the diagnosis or treatment of an Injury or Illness (except where preventive services are payable by the Plan as noted in this document); (4) incurred while the person is covered by the Fund; and (5) Medically Necessary as defined in this section. To be eligible, the Trustees must determine that the expense is intended to be covered and to be reimbursed by the Fund.

Employer

Any Employer that, in accordance with a Collective Bargaining Agreement, participation agreement or other written agreement with the Teamsters Local 807, is contributing to the Fund.

Experimental or Investigational

Any treatment that is not generally accepted in the medical community for the treatment of the condition that is the basis for the claim, and/or any treatment that is deemed by the Trustees as Experimental or Investigational under the guidelines set forth in this Booklet.

Fund

The Local 807 Labor-Management Health Fund.

Fund Office

Local 807 Labor-Management Health Fund
32-43 49th Street
Long Island City, New York 11103
Telephone: 718-274-5353
Fax: 718-728-4413

Health Fund Coverage

A period during which a Covered Person is eligible for benefits.

Hospice

See the "Empire Hospital" section.

Hospital/Facility

A fully licensed acute-care general Facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all Illnesses, accidents and emergencies;
- 24-hour general nursing service with registered nurses who are on duty and present in the Hospital at all times;
- A fully staffed operating room suitable for major surgery, together with anesthesia service and equipment. The Hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care;
- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies;
- Diagnostic radiology Facilities;
- A pathology laboratory;
- An organized medical staff of licensed doctors.

For Pregnancy and childbirth services, the definition of "Hospital" includes any birthing center that has a participation agreement with either Empire BlueCross BlueShield, or another Blue Cross and/or Blue Shield plan.

For physical therapy purposes, the definition of a "Hospital" may include a rehabilitation Facility either approved by Empire BlueCross BlueShield, or participating with Empire or another Blue Cross and/or Blue Shield plan other than specified above.

For kidney dialysis treatment, a Facility in New York State qualifies for In-Network benefits if the Facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the Facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's.

For certain specified benefits, the definition of a "Hospital" or "Facility" may include a Hospital, Hospital department or Facility that has a special agreement with Empire BlueCross BlueShield.

Empire's Hospital Plan does not recognize the following Facilities as Hospitals: nursing or convalescent homes and institutions; rehabilitation Facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps.

For chemical dependence treatment received out-of-area, a Facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A Facility outside of New York State must be approved by the Joint Commission on the Accreditation of Health Care Organizations.

Illness

Any bodily Sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of an Eligible Employee or Spouse will be considered to be an Illness only for the purpose of coverage under the Fund. However, infertility is not an Illness.

Injury

Any damage done to a body part resulting from trauma from an external source.

In-Network Provider

A provider who has contracted with MagnaCare's Preferred Provider Organization, Empire BlueCross BlueShield, S.I.D.S. MetroDENT or with another PPO Network offered from time to time by the Fund to provide services under that contract.

Inpatient

A person physically occupying a room and being charged for the room and board in a Facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Fund and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), or Intermediate Care Unit

A Hospital area or accommodation exclusively reserved for critically and seriously ill Patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a standby basis and which is separated from the rest of the Hospital's Facilities.

Medical Board

A group of Physicians acting as advisors to the Board of Trustees or to one or more of its Third-Party Suppliers.

Medically Necessary

A medical or dental service or supply, provided by or under the direction of a Physician or Dentist, which the Trustees determine in their sole discretion, to be necessary in terms of generally accepted medical standards in the community in which it is provided and which meets all of the following requirements: (i) consistent with the symptoms or diagnosis and treatment of the Patient's condition, Illness or Injury; (ii) in accordance with standards of good medical practice; (iii) not solely for the convenience of the Patient, the family or the provider; and (iv) not primarily custodial; and (v) the most appropriate level of service that can be safely provided to the Patient.

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

Additionally, the fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered Medically Necessary for the medical coverage provided by the Fund.

A hospitalization or confinement to a specialized Hospital will not be considered Medically Necessary if the Patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply will not be considered to be Medically Necessary if it is furnished only because it is available while in the Hospital and/or convenient when the service or supply could safely and more appropriately, and is usually furnished in a Physician's or Dentist's office or other less costly Facility.

The non-availability of a bed in another specialized health care Facility or the non-availability of a Physician to provide medical services will not result in a determination that continued confinement in a Hospital or other specialized health care Facility is Medically Necessary.

A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Physician or Dentist.

Medicare

Health Insurance for the aged as established by Title I of Public Law 89-98, including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Outpatient

Services rendered on other than an Inpatient basis or services rendered at a covered non-Hospital Facility.

Palliative Care

Care provided for the relief of symptoms, pain or stress caused by Illness.

Patient

A person who is in the care of a licensed Physician, or Dentist or other health care professional recognized by the Trustees.

Pensioner

A person receiving any form of pension benefit from the Local 807 Labor-Management Pension Fund.

Physician

A Doctor of Medicine, (M.D.), or Doctor of Osteopathy, (D.O.), who is licensed to practice medicine or osteopathy where the care is provided.

A Physician will also include the following providers, but only when the provider is licensed to practice where the care is rendered, is rendering a service within the scope of that license, is providing a service for which benefits are specifically provided by the Health Care Coverage of the Fund, and when benefits would be payable if the services were provided by an M.D. or D.O.: audiologist, chiropractor (D.C.), Dentist (D.D.S. or D.M.D.), optometrist (O.D.), licensed clinical social worker (L.C.S.W.), marriage family and child counselor (M.F.C.C.), nurse practitioner, physician's assistant (P.A.), physical therapist (P.T. or R.P.T.), occupational therapist (O.T.R.), podiatrist or chiropodist (D.P.M., D.S.P., or D.S.C.), psychologist (Ph.D. or Ed.D.), and speech pathologist. NOTE: The term "Physician" will not include interns, residents, fellows or others enrolled in a residency training program.

Plan

The Local 807 Labor-Management Health Fund's health plan of benefits.

Plan Sponsor

The Board of Trustees of the Local 807 Labor-Management Health Fund.

Plan Year

The 12-month period from September 1 to August 31, unless otherwise established by the Trustees.

Pregnancy

The period in which a child is in utero, childbirth, miscarriage and complications arising therefrom.

Reasonable and Customary

A charge made by a provider which does not, in the sole discretion of the Trustees or a Third-Party Supplier, exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

Relative

A Spouse, parent, brother, sister, or child of the Eligible Employee or of the Eligible Employee's Spouse.

Sickness

Bodily Illness or disease (other than mental health conditions), or congenital abnormalities of a newborn child. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by the Fund.

Skilled Nursing Facility

A public or private Facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Hospitals and Health care Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It maintains on its premises all Facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse, with one licensed Registered Nurse on duty at all times; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, addicted to drugs, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Subrogation

The right of the Fund to be substituted in place of a Covered Person with reference to the person's lawful claim, demand or right of action against a third party who wrongfully caused the Covered Person's Illness or Injury.

Third-Party Suppliers

Any organization utilized by the Fund to provide services to Covered Persons including, but not limited to,

- Empire BlueCross BlueShield;
- MagnaCare;
- Davis Vision;
- Express Scripts;
- Express Scripts by Mail;
- MedReview Medical Management Program provider;
- S.I.D.S. MetroDENT; or
- The Hartford Insurance Company.

Total Disability or Totally Disabled

With reference to an active Eligible Employee, a Disability resulting solely from a Sickness, Injury or Pregnancy which prevents an Eligible Employee from engaging in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. An Eligible Employee who is engaged in any employment or occupation for wage or profit will not be considered Totally Disabled.

Trustees

Individuals appointed by the Union and the Contributing Employers who collectively have the full discretion and final binding power and authority to interpret the Fund's obligations and Plan documents or to make decisions regarding policies, interpretations, practices or procedures of the Fund.

Urgent Care Facility

A freestanding Facility which is engaged primarily in providing minor emergency and episodic medical care and which has a board-certified Physician, a registered nurse (R.N.) and a registered X-ray technician in attendance at all times; and has X-ray and laboratory equipment and a life support system. An Urgent Care Facility does not include a clinic located at, operated in conjunction with, or in any way made a part of, a regular Hospital.

Administrative Provisions

Administration

The Fund is administered by its Board of Trustees.

Administration Expenses

Contributions will also be used to pay administrative expenses of the Fund.

Amendment or Termination of the Fund

The Board of Trustees expects the Fund to be permanent, but since future conditions affecting the Fund or the Employers cannot be anticipated or foreseen, the Administrator must necessarily and does hereby reserve the right:

- To reduce or modify health care benefits;
- To alter or postpone the method of payment of any benefit;
- To amend any provision of these administrative provisions;
- To make any modifications or amendments to the Fund as are necessary or appropriate to meet the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- To terminate, suspend, withdraw, amend or modify the Fund in whole or in part at any time.

Plan benefits and eligibility rules for Participants and Dependents:

- Are not guaranteed or otherwise vested;
- May be changed or discontinued by the Board of Trustees;
- Are subject to the rules and regulations adopted by the Board of Trustees;
- Are subject to provisions of any group insurance policy purchased by the Trustees and to the other Plan Documents that establish and govern the Plan's operations.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

If termination is ever necessary, in accordance with the Fund's Agreement and Declaration of Trust, the Trustees will use Fund assets to pay necessary expenses, and to pay such benefits as the Trustees determine should be paid and for such other purposes that the Trustees decide would best carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been dispersed. After all assets have been disbursed, the Welfare Fund will terminate.

Clerical Error

Any clerical error will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Collective Bargaining Agreements

This Plan is maintained under several Collective Bargaining Agreements. A copy of any such agreement may be obtained by Plan Participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.

Contribution Source

All contributions to the plan are made by Employers in accordance with Collective Bargaining Agreements and participation agreements between Local 807 and Contributing Employers. The Collective Bargaining Agreementsand participation agreements require contributions to the plan at a fixed rate per hour worked. The Fund Office will provide you with information as to whether a particular Employer is contributing to this Plan on behalf of employees working under a Collective Bargaining or participation Agreement.

Facility of Payment

Every person receiving or claiming benefits under the Fund will be presumed to be mentally and physically competent and of age. However, in the event the Fund determines that the Eligible Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Employee has not provided the Fund with an address at which he or she can be located for payment, the Fund may, during the lifetime of the Eligible Employee, pay any amount otherwise payable to the Eligible Employee, to the husband or wife or relative by blood of the Eligible Employee, or to any other person or institution determined by the Fund to be equitably entitled thereto; or in the case of the death of the Eligible Employee before all amounts payable have been paid, the Fund may pay any such amount to one or more of the following surviving relatives of the Eligible Employee: lawful Spouse, child or children, mother, father, brothers, or sisters, or the Eligible Employee's estate, as the Administrator in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Fund.

If a guardian, conservator or other person legally vested with the care of the estate or well-being of any person receiving or claiming benefits under the Fund is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Trustees. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Fund.

Force Majeure

Should the performance of any act required by the Fund be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Fund.

Fund Documents

A copy of Plan or Trust documents may be obtained upon written request to the Fund Manager and is available for examination at the Fund Office.

Funding Medium

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to eligible persons and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Trust Fund as set forth in this document.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Fund Document will not affect the other provisions, but the Fund Document will be construed in all respects as if such invalid provision were omitted.

Insurance Policy(ies) and Third-Party Administrators

Contributions may be used to purchase insurance coverage(s) to ensure that the Fund will meet its Health Care Coverage obligations. These policy(ies) may be reviewed upon written request submitted to the Administrator. The Administrator is also available to answer any questions about the coverage. The provisions of this Document in no way modify those of any insurance policy.

- The Hospital Benefits are self-insured by the Fund and administered by Empire BlueCross BlueShield, P.O. Box 1407, Church Street Station, New York, New York 10008-1407.
- The Medical Benefits are self-insured by the Fund and self-administered by the Fund Office, Local 807 Labor-Management Health Fund, 32-43 49th Street, Long Island City, New York 11103.

- The medical and ancillary services network benefit are self-insured by the Fund and administered by MagnaCare, 100 Garden City Plaza, Garden City, New York 11530.
- The Optical Benefits are self-insured by the Fund and administered by DavisVision, 159 Express Street, Plainview, New York 11803.
- The Prescription Drug benefits are self-insured by the Fund and administered by Express Scripts Health Solutions, Inc., P.O. Box 14711, Lexington, Kentucky 40512.
- The Mail Order Prescription Drug Benefits are self-insured by the Fund and administered by Express Scripts.
- The Dental Benefits are self-insured by the Fund and administered by S.I.D.S. MetroDENT, 71 South Central Avenue, Valley Stream, New York 11582.
- Temporary Disability Benefits are insured through The Hartford Insurance Company, P.O. Box 14303, Lexington, KY 45012-4303.

Legal Actions

No Eligible Employee, Dependent or other beneficiary will have any right or claim to benefits from the Fund, except as specified herein. Any dispute as to benefits under the Fund will be resolved by the Fund Sponsor under and pursuant to the Fund Document.

Misstatement of Age

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of age of a Claimant on an enrollment form or claims filing, his or her eligibility or amount of benefits, or both, will be adjusted in accordance with his or her true age. Upon the discovery of a Claimant's misstatement of age, benefits affected by such misstatement will be adjusted immediately.

Any misstatement of age will neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force.

Physical Examination

The Fund, at its own expense, will have the right and opportunity to have a Physician of its choice examine the Claimant when and as often as it may reasonably require during the pendency of any claim.

Reimbursements

Whenever any benefit payments which should have been made under the Plan have been made by another party, the Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Fund, and the Fund will be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery

Whenever any benefit payments have been made by the Fund in excess of the maximum amount required under the terms of this document, the Fund will have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Eligible Employee or Dependent will make a good faith attempt to assist the Fund.

The Fund may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or service have been provided, the Fund will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or service are not covered hereunder. The Covered Person (or parent, if a minor) will execute and deliver to the Fund all assignments and other documents necessary or useful to the Fund for the purpose of enforcing its rights under this provision. The Fund, in addition to the above described rights, may recoup and recover any amounts paid in excess of amounts allowed under the terms of this Plan by withholding and/or denying future payments the Fund would have paid for medical services provided to such Covered Person or his or her Dependent(s). In the event that a specific benefit payment, if made, would be larger than the amount necessary to satisfy the amount of overpayment, the Fund will be permitted to make a proportional payment to the Participant equal to the amount not subject to recoupment.

Rights Against the Administrator

Neither the establishment of the Fund, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Eligible Employee or any person any legal or equitable rights against the Fund, the Trustees, or other representatives or agents designated by the Trustees.

Substitution

The Fund will be substituted for all rights of an Eligible Employee to recover attorney fees against any adverse party. Eligible Employees will do nothing to prejudice such rights of the Fund and agree to take all necessary steps to preserve and take advantage of such rights. If payment has been made by the Fund in such instances and if the adverse party reimburses the Eligible Employee directly, the Fund will have the right to recover such payment from an Eligible Employee.

Taxes

Any premium or other taxes which may be imposed on the Plan by any state or other taxing authority will be paid by the Fund.

Titles or Headings

Where titles or headings precede explanatory text throughout this Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of this Document and will not affect the validity, construction or effect of the Fund Document provisions.

Trustee Responsibility, Authority and Discretion

The Trustees will discharge their duties under the Fund solely in the interest of the Eligible Employees and their Beneficiaries and for the exclusive purpose of providing benefits to Eligible Employees and their Beneficiaries and defraying the reasonable expenses of administering the Fund.

The Trustees will have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, construe, amend and interpret the provisions of the Plan, this document and the terms used therein, as well as all other Plan Documents, including the Trust Agreement, and to decide all matters arising in connection with the operation or administration of the Fund. The authority of the Trustees includes, without limitation, the sole and absolute discretion to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund, this document and the Trust Agreement;
- Decide questions, including legal or factual questions, relating to the determination and payment of benefits;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, this document and the Trust Agreement; and
- Process, and approve or deny, benefit claims and rule on any benefit exclusions or limitations.

All determinations made by the Trustees with respect to any matter will be final, conclusive and binding upon, the Employers, the Employees, the Covered Persons, and their Beneficiaries. The Trustees will be the sole judges of the standard of proof required in any matter. Any decision of the Trustees will only be reversed by a court if such decision is determined to be arbitrary and capricious.

The Administrator may employ such agents, attorneys, accountants, investment advisors or other persons as in their opinion may be desirable for the administration of the Fund, and may pay any such person reasonable compensation. The Trustees may delegate to any agent, attorney, accountant or other person selected by them, any power or duty vested in, imposed upon, or granted to them by the Fund.

Type of Fund

This is a Voluntary Employee Benefit Association established under Section 501(c)(9) of the Internal Revenue Code to provide certain welfare benefits for Eligible Employees, their Eligible Dependents, and Qualified Beneficiaries under COBRA.

A complete list of the Employers participating in the Fund may be obtained upon written request to the Administrator, and is available for examination by Covered Persons and their beneficiaries at the office of the Fund. Covered Persons and their Beneficiaries may receive from the Fund, upon written request, information as to whether a particular employee organization is participating with the Fund and, if the organization is participating, the address of such entity.

Worker's Compensation

The benefits provided by the Fund are not in lieu of and do not affect any requirement for coverage by Worker's Compensation Insurance laws or similar legislation.

General Plan Information

Name of Fund	Local 807 Labor-Management Health Fund
Sponsor and Administrator	Board of Trustees of the Local 807 Labor-Management Health Fund
Address	32-43 49th Street Long Island City, New York 11103
Business Phone Number	718-274-5353
Sponsor ID Number (EIN)	13-5548780
Number	501
Plan Year	September 1 through August 31
Benefits	Health and Welfare Benefits
Designated Legal Agent	Board of Trustees of the Local 807 Labor-Management Health Fund
Address	32-43 49th Street Long Island City, New York 11103

Legal process may be served upon the Board of Trustees or any one Trustee. For disputes arising under those portions of the Plan regarding Temporary Disability Benefits insured by The Hartford Insurance Company, service of legal process may be made upon The Hartford Insurance Company at one of their local offices, or upon the supervisory official of the State Insurance Department in the state in which you reside.

Board of Trustees

Union Trustees

John Sullivan
Local Union 807, I.B.T.
32-43 49th Street
Long Island City, NY 11103

Luis Herrera
Local Union 807, I.B.T.
32-43 49th Street
Long Island City, NY 11103

Anthony Storz
Local Union 807, I.B.T.
32-43 49th Street
Long Island City, NY 11103

Employer Trustees

Allen Swerdlick
Kamco Supply Corporation
80 21st Street
Brooklyn, New York 11232

Anthony Zappulla
McKinney Welding Supply Co., Inc.
535 West 52nd Street
New York, New York 10019

John Zak, Sr.
Airweld, Inc. Co., Inc.
94 Marine Street
Farmingdale, New York 11735

Fund Manager Alfred Fernandez

Statement of ERISA Rights of Covered Persons

Generally

As a Participant in the Local 807 Labor-Management Health Fund, you are a "Covered Person" entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) ERISA provides that all plan Participants will be entitled to:

- Receive information about your Fund and benefits.
- Examine, without charge, at the Plan Administrator's office and at 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 and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the 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. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Fund as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage.
- Review this summary plan description and the documents governing the Fund and the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this employee 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 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 so long as you have exhausted all administrative remedies required in this Booklet. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If 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 is frivolous.

Assistance with Your Questions

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

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