**BUILDING TRADES WELFARE BENEFIT FUND**
**50 Charles Lindbergh Blvd.**
**Suite 207**
**Uniondale, New York 11553 (516) 833-9300**
**FAX (516) 833-9350**

July 1, 2016

Dear Participant:

We are pleased to present you with this Summary Plan Description ("SPD") describing the benefits provided by the Fund. The Fund will inform you of any changes to your benefits as required by law. We suggest you review this material carefully in order to take full advantage of the benefits provided.

Benefits are provided to all eligible Employees of Contributing Employers that have been accepted to participate in the Fund and on whose behalf, the Contributing Employer is making contributions to the Fund. Your Contributing Employer is required to make specified contributions to the Fund. Participants and Dependents may receive, upon written request to the Fund Office, information as to whether a particular employer is a Contributing Employer and if so, that employer's address.

The Fund is administered by a Board of Trustees. The Board of Trustees has the power to interpret the provisions of this document and the terms used therein. Any such interpretation adopted by the Trustees in good faith will be binding upon you and your eligible Dependents.

Should you require any information or explanation, or need assistance in filing a claim for benefits, please feel free to contact the Fund Office at 50 Charles Lindbergh Blvd. Suite 207, Uniondale, New York 11553: Telephone (516) 833-9300. You may also obtain further information about the Fund or contact the Fund Office through the Fund's website: http://www.buildingtradeswelfund.org/index.html.

Sincerely,

The Board of Trustees

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## GENERAL INTRODUCTION

This document is both the Plan Document, and the Summary Plan Description, of the Building Trades Welfare Benefit Fund – Plan D, for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The terms contained herein constitute the terms of the Plan. It is subject to administrative modification and interpretation by the Board of Trustees, and to the rules, regulations and procedures of the Plan in effect at the time your claim is made. The Board of Trustees has the right to interpret the terms of this document in situations not expressly addressed in this document. Capitalized terms are defined in the "Definitions" section of this SPD, beginning on page 18.

You should note, however, that the Trustees, in their sole and exclusive discretion, may, from time to time, change, amend, modify, discontinue and/or terminate in whole or in part, the benefits described in this Plan. If any benefit changes occur, the Fund Office will notify all Participants in accordance with applicable law.

The Board of Trustees has contracted with the insurance companies identified on page 41 to provide life insurance and AD&D benefits. If you need additional copies of the booklets prepared by the insurance companies that describe the insurance benefits available to you, you may request copies from the Fund Office. Taken together, all of these documents describe the benefits under the Fund and constitute the Summary Plan Description and Plan Document for the Building Trades Welfare Benefit Plan - Plan D. The Insurance Companies have the discretion to make determinations about benefits provided under the insurance contracts. The Trustees have the right to change Insurance Companies or to change the contracts to reduce or eliminate the benefits provided to you and your Dependents. If you have trouble understanding any part of this material, contact the Fund Office. The address is 50 Charles Lindbergh Blvd. Suite 207, Uniondale, New York 11553 Telephone: (516) 833-9300. The Fund Office hours are 9:00 A.M. to 5:00 P.M.

The Summary Schedule of Benefits ("Schedule") found on page 5 summarizes the benefits generally applicable to your coverage, although the benefits contained in the Schedule may be revised from time to time. **Accordingly, it is absolutely necessary that you verify coverage with the Fund Office before incurring medical Expenses so that you can be sure that there is coverage under the Plan for you or your Dependents.**

**Please remember that no one other than the Fund Office can verify your coverage. Do not rely upon any statement regarding coverage or benefits under the Fund made by your Employer, or anyone else other than the Fund Office staff.**

It is extremely important that you keep the Fund Office informed of any change in address, desired changes in beneficiary or information regarding your Dependents. This is your obligation and you could lose benefits if you fail to do so. The importance of a current, correct address and current correct information (including Social Security numbers) regarding your Dependents on file in the Fund Office cannot be overstated. It is the ONLY way the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

## PRE-CERTIFICATION/MANAGED CARE AND SECOND SURGICAL OPINION

In the event you or your eligible Dependent requires Hospital confinement or surgery, you must call American Health Holdings, Inc., 1-866-457-9882 prior to the surgery or Hospital confinement, and tell the pre-certification operator that you are a member of the Building Trades Welfare Benefit Fund. The phone call is absolutely free.

### WHEN SHOULD YOU CALL?

For **Elective (planned) Hospital Confinement**, please call at least fourteen (14) days prior to admission. If you are going to be admitted sooner than fourteen days, call the toll-free number as soon as you know what day you will be Hospital confined.

For **Emergency Hospital Confinement**, please call within 48 hours after your admission. You may have a spouse, relative, friend, or even your doctor can make the call for you.

For **Maternity Cases**, please call within the first three (3) months of conception, or as soon as possible after confirmation of pregnancy, and again when you are hospitalized.

For **In-patient or Out-patient Surgery**, please call at least fourteen (14) days prior to planned surgery when recommended by your doctor.

### WHAT INFORMATION SHOULD BE REPORTED?

When calling 1-866-457-9882 for pre-certification, please give the name, address, social security number, and age of the patient, the Participant's social security number (if the Participant is not the patient), name of employer, date of planned admission or surgical procedure. You should also give your doctor's name, address and telephone number.

### WHAT HAPPENS IF YOU DON'T CALL?

If you do not call American Health Holdings for Hospital pre-certification, emergency Hospital confinement or for selected in-patient or out-patient surgery, you may incur a penalty. If you fail to pre-certify and your treatment is determined to be Medically Necessary, you may incur a $200 penalty. If you fail to pre-certify and your treatment is determined not to be Medically Necessary, coverage for your treatment may be denied and you may be required to pay the Hospital bill yourself. There is no cost to you for making the call. All information given will be completely confidential.

The Board of Trustees is always concerned with the ever-increasing costs of providing healthcare services, and we all have a role to play in seeing that medical care remains affordable. You, as a claimant, must be sure that your benefit payments are for care and treatment that is

necessary and at a reasonable charge. You will help this effort greatly by complying with the pre-certification requirements and calling American Health Holdings prior to treatment.

## ACCESSING THE PROVIDER NETWORK

The Fund has arranged for you to have access to a network of Physicians, surgeons, labs and X-ray facilities in the Greater New York area. These benefits as well as discounted Hospital bills, are provided through a contract with Empire Blue Cross Blue Shield/Anthem ("BCBS").

In order to help you get the best possible results in utilizing this network, the Fund requires you to follow these simple guidelines:

1) Please call the Fund Office if you have any questions regarding what benefits are provided by the Fund and whether or not you are responsible for Co-payments or Coinsurance.

2) After selecting a BCBS provider from the online directory or by calling 1-800-810-BLUE, simply call to make an appointment. Be sure to verify that the service provider you are calling is part of the BCBS network.

3) If you need help in selecting a provider, you may call BCBS directly at 1-800-810-BLUE or by accessing the Internet at www.Anthem.com

4) When you arrive at the doctor's office, present your BCBS card or identify yourself as a BCBS participant. Be prepared to give your social security number and identify yourself as being a member of the Building Trades Welfare Benefit Fund. Your Dependents should also use your social security number. You will be responsible for your Co-payment, if applicable, at this time.

5) If your doctor requires lab work or X-rays, be sure to advise him that you would like the work to be done by a participating BCBS lab or facility. BCBS doctors know which labs and X-ray facilities are in the BCBS network.

6) If you or your Dependents require hospitalization, be sure to advise your doctor that you would like to be admitted to a BCBS Hospital.

7) If you receive a bill from a BCBS lab, do not ignore it. Complete the information section of the bill using your social security number and the Building Trades Welfare Fund group information. Send the lab bill to the Fund Office at 50 Charles Lindbergh Blvd. Suite 207, Uniondale, New York 11553.

8) All Plan maximums and limitations found in this Summary Plan Description booklet will apply.

With your BCBS identification cards, you may go to any medical doctor in the BCBS network for an office visit. You will be required to make only a $20 Co-payment for a visit with a

primary care physician and $40 Co-payment for a visit with a specialist. All other services such as X-rays and lab tests are subject to the Co-payments and Coinsurance described in the Schedule of Benefits. You are not required to use a primary care Physician. A directory of providers is available online through the BCBS website (www.Anthem.com) or by calling 1-800-810-BLUE.

Remember, it is your responsibility to make sure that each Physician, surgeon, Hospital, lab and X-ray facility you use is part of the BCBS network. If you have any questions as to whether or not a provider is part of BCBS, please call the BCBS Customer Service Department at 1-800-676-BLUE.

You may choose to use a doctor who is not part of the BCBS network. If this is the case, you will need to complete a claim form and have the claim processed as explained in the claims information section, beginning on page 62 of this document. Please be advised that you may be responsible to pay more for your services if you use a non-BCBS provider. It is important that you keep the Fund Office advised of any change in your address or family status. Your failure to do so could affect your benefit status.

## HOW THE PLAN WORKS

### Overview

The medical benefits under this Plan are provided in two parts: Basic Plan benefits, which include hospital and medical, and other benefits such as prescription drugs, which are provided by the Fund through contracts with other service providers.

### The Basic Plan Benefits

The Basic Plan consists of those Customary Charges for which benefits are generally payable at 100%, subject to certain limits specified in the Schedule of Benefits, and Co-payments.

Described later in this booklet, these are:

Hospital Expense Benefits
Surgical Expense Benefits
Medical Expense Benefits
Medical Consultation Benefits
X-Ray and Diagnostic Expense Benefits
X-Ray and Radioactive Therapy Benefits
Supplementary Expense Benefits
Routine Physical Examination Benefit

### Other Plan Benefits

Prescription Drug Benefits
Home Health Care

## SUMMARY SCHEDULE OF BENEFITS

### Basic Plan Benefits for Participants and Dependents

***Hospital Expense Benefit***

Maximum Daily Hospital Room and Board Benefit:

For Ward and Semi-Private Accommodations: Full Cost up to 120 days and 50% of all Hospital Services for the next 180 days, subject to a Co-payment of $250.

For Private Accommodations: Full Cost of the Semi-Private Accommodations and 50% of all Hospital Services for the next 180 days, subject to a Co-payment of $250

For Intensive Care: Full Cost of the highest Semi-Private Accommodation for the first 120 days and 50% of the highest Semi-Private Accommodation for the next 180 days, subject to a Co-payment of $250.

Out-of-Network Hospital benefits are covered at 80% of the Usual and Customary Charge, except for emergency services, which are covered up to the amount the Fund

would have paid if the emergency services were provided at an in-network Hospital. Any difference between the billed amount and the in-network rate is your responsibility.

Pre-admission testing is covered only if provided at an in-network facility and is subject to a $50 Co-payment.

All Hospital admissions are must be pre-certified.

***Home Health Care Expense Benefit***

The Plan will cover the cost of coverage with an in-network provider, subject to a $40 per visit Co-Payment.

Maximum Number of Home Health Care Visits per Continuous 12 Month Period: 40

No out-of-network coverage

***Skilled Nursing Facility Expense Benefit***

For services with an in-network provider, the Plan will pay the full cost for up to 30 days, subject to a Co-Payment of $250. The 30-day maximum is combined with inpatient rehabilitation services.

No out-of-network coverage

Pre-certification required

***Surgical Expense Benefit***

$250 Co-payment for an in-network surgeon. There is a separate facility Co-payment -- $100 at an in-network ambulatory surgical center and $250 if performed in-patient at an in-network Hospital. Out-of-network non-emergency procedures are covered at 80% of the Usual and Customary Charge.

Pre-certification required

***Medical Expense Benefit***

Co-payment of $20 per visit for a primary care physician and $40 per visit for a specialist

No out-of-network coverage

***Medical Consultation Benefit***

Co-payment of $40 per visit

No out-of-network coverage

***Annual Physical Examination Benefit***

(includes weight, blood work, electrocardiogram, chest x-ray, blood pressure and mandatory mammography)

The Plan pays 100% of the cost with an in-network provider.
Maximum Benefit per calendar Year: 1 visit
No out-of-network coverage

***X-Ray and Diagnostic Expense Benefit***

Co-payment of $50 per visit.
MRIs and PET scans are subject to a Co-payment of $100
No out-of-network coverage

***Chemotherapy & Dialysis***

If administered at an in-network facility on an out-patient basis, the Fund will cover the full cost, subject to a $40 Co-payment per treatment.

For services rendered on an in-patient basis at any facility or at an out-of-network facility, the Fund will cover 80% of the Usual and Customary Charges.

***Durable Medical Equipment***

The Fund will cover 80% of the PPO rate through an in-network provider. There is no out-of-network coverage. If the cost of the equipment exceeds $500, your claim must receive advance approval from the Fund Office. If you do not obtain advance approval, the Fund will not cover the cost.

***Prescription Drug Benefit***

Co-Payment Per Prescription:

$10.00 for Generic drugs, $25.00 for Brand name and $35 for non-formulary prescriptions filled at a participating Pharmacy.
$20.00 for Generic drugs, $50.00 for Brand name and $70 for non-formulary prescriptions for a 90-day supply filled through the Fund's Mail Order Program.
Subject to an out-of-pocket maximum of $1,000 per person and $2,000 per family.

Specialty Drugs are not covered

Prescription Drug Benefits are provided through American Health Care and are subject to the limitations described on pages 37 -39.

***Out-of-Pocket Expenses***

After $5,850.00 per individual and $11,700 per family of Covered Expenses have been paid by you during any one calendar year, 100% of all Covered Expenses will be payable during the remainder of that calendar year.

The following expenses are not included in these out-of-pocket maximums:

1. Prescription Drugs, which are subject to separate out-of-pocket maximums;
2. Services provided by out-of-network providers,

3. Expenses due to the difference between the Usual & Customary Charge for services and the amount charged by the out-of-network provider for those services;
4. Expenses payable at 100%.

**Life and Accidental Death & Dismemberment Insurance (Employees only)**

Life Insurance (Employee) .....$20,000.00
Accidental Death and Dismemberment Principal Sum (Employee).....$20,000.00

## GENERAL INFORMATION

### WHO IS ELIGIBLE?

All Employees on whose behalf contributions are made to the Fund and who meet the eligibility requirements described in this Section, are eligible for benefits.

### WHEN AM I ELIGIBLE?

For each three-month Contribution Period described below that you work an average of 120 hours per month and your Employer makes contributions to the Fund on your behalf, you and your Dependents will be covered under the Plan for corresponding three-month Coverage Period.

| CONTRIBUTION PERIOD | COVERAGE PERIOD |
|---|---|
| January, February, March | August 1 – October 31 |
| April, May, June | November 1 – January 31 |
| July, August, September | February 1 – April 30 |
| October, November, December | May 1 – July 30 |

For example, if you work an average of 120 hours per month during July, August and September 2016 and your Employer properly makes contributions to the Fund on your behalf for these months, you and your Dependents will be covered for February, March and April 2017.

For all new Employees, eligibility for benefits will begin on the first day after you have worked in Covered Employment for an average of 120 hours per month for three months or 360 hours in the preceding three months, and the Fund has timely received contributions from your Employer on your behalf for these months, or as otherwise provided in the collective bargaining agreement or other written agreement governing your participation in the Fund. You will continue to be covered for each successive three-month period, provided you continue to work sufficient hours to maintain coverage and your Employer timely makes contributions to the Fund on your behalf. Assuming you continue to work an average of 120 hours per month over three months and your Employer continues to make timely contributions to the Fund on your behalf, your contribution/eligibility cycle will eventually fall into sync with the cycle described above for current Participants.

If your coverage has terminated because of a disability and you subsequently return to Covered Employment, you will receive coverage for each month your Employer makes a contribution to the Fund on your behalf, until you sync up with the quarterly eligibility cycle described above for current Participants.

## UNDER WHAT CIRCUMSTANCES MIGHT I BECOME INELIGIBLE OR RISK DENIAL, FORFEITURE, SUSPENSION, OR REDUCTION OF BENEFITS?

*Current Employees*

Once you begin receiving benefits under the Plan, you will continue to be covered until the end of the Coverage Period for which you did not work sufficient hours to maintain eligibility or for which employer contributions are not received during the corresponding Contribution Period. If you terminate Covered Employment or work less than an average of 120 hours per month during a Coverage Period, you will continue to receive coverage for the remainder of that Coverage Period. At the end of that Coverage Period, your coverage will terminate. Coverage will also terminate if your employer is delinquent in any contributions owed on your behalf during the corresponding Contribution Period.

After 12 consecutive months of participation in this Plan D, you will automatically be covered under the Fund 's Plan A program of benefits. Once you become a participant in Plan A, you will remain covered under that program pursuant to the rules described in the Fund's plan document for Plan A, except that if you lose coverage under Plan A and do not regain eligibility within 12 months of the date your coverage terminated, then upon your recommencement of work in Covered Employment and upon meeting the eligibility requirements, your coverage will be under this Plan D for a 12-consecutive month period, unless terminated earlier pursuant to rules described beginning on page 11.

## ARE MY DEPENDENTS ELIGIBLE?

Your eligible Dependents are:

(a) your legal spouse of the opposite sex; and

(b) each eligible child as described beginning on page 18,

provided your Dependent(s) are listed on the Fund Enrollment Card on file with the Fund Office. In the event that both parents are Participants in the Fund, then such child will be considered a Dependent of one of the parents, but not both.

An eligible Dependent who is not listed on a Fund Enrollment Card will be enrolled in coverage if required by a Qualified Medical Child Support Order ("QMCSO"). The Fund will provide coverage to a child under a QMCSO to the extent required by law. If the Fund receives a QMSCO and if the Participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is QMCSO can be obtained free of charge from the Fund.

The Fund also will provide Dependent coverage for a child that is placed for adoption with a Participant regardless of whether the adoption is finalized. A child will be considered placed for adoption with a Participant if the Participant assumes a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child's placement with the

**BUILDING TRADES WELFARE BENEFIT FUND**
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February 19, 2019

The Board of Trustees of the Building Trades Welfare Benefit ("Fund") has adopted the following changes to Plan D of the Building Trades Welfare Benefit Plan ("Plan") regarding when coverage terminates. Please keep this document with your Summary Plan Description ("SPD").

1. **Effective March 1, 2019, the language in the first paragraph on page 10 of the SPD under the section titled "Under What Circumstances Might I Become Ineligible Or Risk Denial, Forfeiture, Suspension, Or Reduction Of Benefits?" is deleted and replaced with the following language:**

*Current Employees*

Except as otherwise provided in this paragraph, once you begin receiving benefits under the Plan, you will continue to be covered until the end of the Coverage Period for which you did not work an average 120 hours per month in covered employment for a Contributing Employer during the corresponding Contribution Period, provided contributions are actually received by the Fund on your behalf for those hours. If you terminate Covered Employment or work less than an average of 120 hours per month during a Coverage Period, you will continue to receive coverage for the remainder of that Coverage Period, unless, during the Coverage Period, you work in the type of employment covered by the Plan for a non-contributing employer. In that case, your coverage will terminate on the later of (1) March 1, 2019 or (2) date you begin working for such non-contributing employer. Otherwise, your coverage will terminate at the end of that Coverage Period. Coverage will also terminate at the end of a Coverage Period if your employer is delinquent in any contributions owed on your behalf during the corresponding Contribution Period.

2. **Effective March 1, 2019, the language on pages 11 and 12 of the SPD under the section titled "When do Benefits Terminate?" is deleted and replaced with the following language:**

Your benefits, and those of your eligible Dependents, will terminate on the last day of the Coverage Period in which you fail to maintain eligibility for any reason except Total Disability, certain periods of military service or leave under the Family Medical Leave Act. If your coverage terminates due to Total Disability or maternity, your eligibility for benefits, and those of your Dependents, will continue for six (6) months from the last day of the month in which your Total Disability or maternity occurred. Thereafter, (after the initial 6 months) benefits will continue for an additional 6 months but only for claims relating to the disability that caused the initial cessation of employment. Notwithstanding the foregoing, if you begin working in the types of employment covered by the Fund for the non-contributing employer, your coverage will end on the later of (1) March 1, 2019 or (2) date you begin working for such non-contributing employer.

Benefits for your Dependent also will terminate on the date when that individual ceases to be a Dependent.

All benefits terminate immediately if the Plan is terminated or if your Employer ceases to be a Contributing Employer to the Fund. Except as otherwise provided in this Section, if you fail to work the required number of hours to continue coverage and/or your Employer fails to make required contributions to the Fund on your behalf, eligibility for you and your Dependents will terminate on the last day of the Coverage Period for which contributions were properly made on your behalf during the corresponding Contribution Period. However, prescription drug benefits will continue for six consecutive months following the last month for which contributions that were required to be made are not received by the Fund. In addition, benefits for Dependents terminate on the effective date of any amendment to the Plan eliminating coverage for Dependents.

All benefits for you and your Dependents may be terminated if you work the type of employment covered by the Fund for a non-contributing employer or if your employer has failed to make the required contributions to the Fund on your behalf when due. If your employer is delinquent in its contributions, consistent with the Fund's Policy for Collection of Delinquent Contributions, the Fund will attempt to notify you of such delinquency prior to any termination of your coverage, although it is not required to do so.

After being covered under this program for 12 consecutive months, you will automatically be covered under the Fund's Plan A program of benefits as long as you continue to work the required number of hours in covered employment during the Contribution Period and your Employer timely makes contributions to the Fund on your behalf.

**Grandfathered Status under the Patient Protection and Affordable Care Act**

This group health plan 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 Building Trades Welfare Benefit Fund at 516-833-9300. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform

Participant will be considered terminated when the Participant's obligation to support the child has terminated. A Participant will be required to supply evidence to the Fund that a child for whom Dependent coverage is requested has actually been placed with the Participant for adoption.

## WHEN ARE MY DEPENDENTS ELIGIBLE?

Your Dependents who are listed on the Fund Enrollment Card on file with the Fund are eligible for benefits on the same day that you become eligible. If you are eligible for benefits, then your newborn Dependent child is immediately eligible for coverage at birth for Injury, Sickness, premature birth, or congenital disease or anomaly, provided you properly enroll the newborn child by providing the Fund Office a copy of the child's Social Security Number and birth certificate within thirty (30) days of birth. If you and/or your Dependents decline coverage under this Plan because you and/or your Dependents are covered under either the State Children's Health Insurance Program ("CHIP") or under Medicaid and you lose eligibility for this coverage or you become eligible for financial assistance under either of these programs, you and your Dependents may be able to enroll in Fund coverage so long as you and your Dependents satisfy all the eligibility requirements described in this SPD. If you notify the Fund within 60 days of losing coverage under CHIP or Medicaid or becoming eligible for financial assistance, coverage will be effective retroactive to the date CHIP or Medicaid coverage terminated or financial assistance was granted. Otherwise, coverage is effective on the date notice is received by the Fund.

## HOW DO I ENROLL IN THE PLAN?

You must fully complete a Fund Enrollment Card. This card must include the names, sex, social security numbers, and dates of birth for you and all Dependents you wish to have covered. The Fund cannot process your claim for benefits if it does not have a properly completed card. Enrollment cards may be obtained by calling or writing to the Fund Office. You may add or remove Dependent(s) by completing a new Fund Enrollment Card. The eligibility of added Dependent(s) is determined under the provisions described above.

## HOW DO I HANDLE A CHANGE IN FAMILY STATUS?

If a change occurs in your family status by reason of marriage, birth of a child, adoption of a child or the placement for adoption of a child, death, divorce, or legal separation, you must notify the Fund Office immediately. Under any of these circumstances, a new Fund Enrollment Card must be completed.

## WHEN DO BENEFITS TERMINATE?

Your benefits, and those of your eligible Dependents, will terminate on the last day of the Coverage Period in which you fail to maintain eligibility for any reason except Total Disability, certain periods of military service or leave under the Family Medical Leave Act. If your coverage terminates due to Total Disability or maternity, your eligibility for benefits, and those

of your Dependents, will continue for six (6) months from the last day of the month in which your Total Disability or maternity occurred. Thereafter, (after the initial 6 months) benefits will continue for an additional 6 months but only for claims relating to the disability that caused the initial cessation of employment.

Benefits for your Dependent also will terminate on the date when that individual ceases to be a Dependent.

All benefits terminate immediately if the Plan is terminated or if your Employer ceases to be a Contributing Employer to the Fund. If you fail to work the required number of hours to continue coverage and/or your Employer fails to make required contributions to the Fund on your behalf, eligibility for you and your Dependents will terminate on the last day of the Coverage Period for which contributions were properly made on your behalf during the corresponding Contribution Period. However, prescription drug benefits will continue for six consecutive months following the last month for which contributions that were required to be made are not received by the Fund. In addition, benefits for Dependents terminate on the effective date of any amendment to the Plan eliminating coverage for Dependents.

All benefits for you and your Dependents may be terminated if your employer has failed to make the required contributions to the Fund on your behalf when due. If your employer is delinquent in its contributions, consistent with the Fund's Policy for Collection of Delinquent Contributions, the Fund will attempt to notify you of such delinquency prior to any termination of your coverage, although it is not required to do so.

After being covered under this program for 12 consecutive months, you will automatically be covered under the Fund's Plan A program of benefits as long as you continue to work the required number of hours during the Contribution Period and your Employer timely makes contributions to the Fund on your behalf.

## IF MY BENEFITS END, CAN I CONTINUE BENEFITS BY PAYING FOR THEM MYSELF?

Yes, under certain conditions, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for you and your Dependents to continue health coverage for specified periods of time after your coverage is terminated. This booklet contains a section describing COBRA continuation coverage beginning at page 41. Coverage may also be available while you are in military service, as described below.

## CONVERSION

In certain circumstances, when your coverage for the Life and Accidental Death and Dismemberment benefits terminates, you may continue these benefits through an individual policy. Please refer to the attached booklets from the insurance providers for more details.

## HOW DOES MILITARY SERVICE AFFECT MY ELIGIBILITY FOR BENEFITS?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to Participants who are absent from Covered Employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

### Coverage Under USERRA

A Participant who is absent from employment by reason of service in the uniformed services can elect to continue coverage for the Participant and his or her eligible Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which the Participant's absence begins and ends on the earlier of:

1. The end of the 24-month period beginning on the date on which the absence begins; or

1. The day after the date on which the Participant is required to but fails to apply under USERRA for or return to a position of employment covered under the Fund. (For example, for periods of service over 180 days, generally the Participant must reapply for employment within 90 days of discharge.)

This right to temporarily continue group health coverage does not include any life insurance benefits, accidental death and dismemberment benefits, or other similar non-health benefits provided under the Fund. In addition to the right to continued coverage under USERRA, Participants or Dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Please refer to the COBRA Section of your SPD for more information.

If the Participant met the Plan's eligibility requirements at the time he or she entered the uniformed services, the Participant will not be subject to any additional exclusions or a waiting period for coverage under the Fund upon return from uniformed service, to the extent required by USERRA.

### Notice and Election of USERRA Coverage

The Participant must notify his or her Employer or the Fund Office of the absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If the Participant wishes to elect USERRA coverage, he or she also must notify the Fund Office within 60 days of the last day of employment unless the Participant is excused from giving advance notice of service under the provisions of USERRA. While an Employee may notify an employer of service orally, the Fund requires that Participants elect USERRA coverage in writing. The Fund will provide you with the necessary forms.

### Paying for USERRA Coverage

The Participant may be required to pay all or a portion of the cost of coverage during USERRA leave. If the period of military service is less than 31 days, there is no charge for this coverage beyond the normal Coinsurance or Co-payments that would be paid if the Participant were employed. If the military service extends more than 31 days, the Participant must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to timely make all required payments. The Fund will <u>not</u> send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to untimely payment.

## WHAT HAPPENS TO MY COVERAGE IF I TAKE FMLA LEAVE?

The Family and Medical Leave Act of 1993 ("FMLA") generally requires that an employer with 50 or more Employees provide Participants with up to twelve (12) weeks per year of unpaid leave in the case of the birth or adoption of your child and for your own illness or to care for a seriously ill child, spouse or parent. You may also be entitled to FMLA leave for a qualifying

exigency that arises in connection with the active military service of your child, spouse, or parent. A qualifying exigency includes (a) notification of military deployment within 7 days of the deployment date; (b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; (c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; (d) making financial and legal arrangements; (e) attending counseling sessions; (f) up to 5 days of rest and recuperation; (g) attendance at post-deployment activities.

You may be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service. Contact the Fund Office for more information.

In compliance with the provisions of the FMLA, your Contributing Employer may be required to maintain your coverage under the Plan during the period of your leave under the FMLA. If you are entitled to coverage under the Plan during a period of time under the FMLA, your coverage as a Participant on FMLA leave will cease once the Fund is notified or otherwise determines that you have terminated employment, exhausted your FMLA leave entitlement or you inform the Fund of your intent not to return from leave. Once the Fund is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect Continuation Coverage under COBRA, as described under the COBRA section of this booklet. The event entitling you to coverage under COBRA occurs on the last date of FMLA leave. The Fund cannot condition your entitlement to coverage under COBRA on your reimbursing the Contributing Employer for premiums associated with the cost of coverage during the FMLA leave period, as discussed below.

If you return to Covered Employment for 30 days, the Contributing Employer may not seek to recover the value of the benefits paid. However, if you fail to return to active employment with a Contributing Employer following a period of FMLA leave, the Contributing Employer may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave. If you fail to return from FMLA leave because of the continuance, recurrence or onset of a serious health condition that affects you, your spouse, child or parent, and such health condition would have entitled you to FMLA leave, then the Contributing Employer will not seek to recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave.

## WHAT HAPPENS IF MY SPOUSE ALSO HAS HEALTH COVERAGE?

Members of a family are often covered by more than one Health Plan. As a result, two or more plans may pay for the same Expense. To avoid this costly problem, this Plan provides a Coordination of Benefits program. This provision affects you and all of your Dependent(s). It does not apply to Life or Accidental Death and Dismemberment coverage. All medical/hospital and prescription drug benefits covered under the Plan are subject to the coordination of benefits provisions described in this booklet. To implement coordination of benefits, you may be asked periodically to provide information to the Fund Office about other coverage you or your dependents have. Failure to timely provide the requested information may result in a delay in paying claims on your behalf.

This Section will apply in determining the benefits of a person covered under this Plan and another Health Plan during any Claim Determination Period. In such case, the Covered Expenses incurred by that person will be no more than:

(1) the benefits that would be payable under this Plan in the absence of this provision; and

(2) the benefits that would be payable under all other Health Plans in the absence of provisions in those Health Plans of similar purpose to this provision; would exceed the Covered Expense.

As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision will be reduced to the extent necessary, so that the sum of the reduced benefits and of all of the benefits payable under all other Health Plans (except as described below) will not exceed the total of the Covered Expenses. Benefits payable under other Health Plans include the benefits that would have been payable had a claim been made.

***Which Plan Pays First?***

The Health Plan under which benefits are payable first is referred to as the primary plan. All other plans are called secondary plans. The rules for determining which Health Plan has the primary responsibility for benefit payments are as follows:

(1) If one Health Plan does not contain a Coordination of Benefits provision, it will automatically be primary and pays first;

(2) If the claimant is covered as an Employee under one Health Plan and a Dependent under the other, then the Health Plan under which the claimant is covered as an Employee is primary and pays first;

(3) If the individual is covered as an Employee under two Health Plans, the plan which has covered him the longest is primary and pays first.

The rules below determine which plan's benefits are payable first if a Dependent child is covered under two or more Health Plans:

(1) *If the parents are not divorced or legally separated:*

If the claimant is a Dependent child under both Health Plans, the Health Plan covering the parent whose birth date falls earlier in the calendar year is primary and pays first. If the birthday of both parents occurs on the same date, the plan which has covered the parent for the longer period of time pays first. However, if the Health Plan with which this Plan is coordinating benefits bases its coordination on sex, then the rule in the other plan will determine the order of payment, except if the parents are divorced or legally separated.

(2) *If the parents are divorced or legally separated the following rules will apply:*

(A) When a court decree has established which parent has financial responsibility for the child's health care Expenses, then that parent's Health Plan will be primary;

(B) When financial responsibility has not been legally determined, or such responsibility is equally divided, then the Health Plan that covers the child of the parent with legal custody will be primary;

(C) If the parent with legal custody remarries, then the primary responsibility will lie with the Health Plan that covers the first applicable of the following:

(i) the natural parent with whom the child resides;

(ii) the step-parent with whom the child resides;

(iii) the natural parent not having custody of the child;

(iv) if a Participant or Dependent has Medicare as primary coverage, the benefits will be coordinated in accordance with federal law regarding Medicare coverage;

(v) if none of the above applies, then the Health Plan in which the claimant has been enrolled the longest will be primary.

## DEFINITIONS

***Child Wellness Charge*** means a charge for a complete physical, including hearing, vision and routine laboratory exams.

***Claim Determination Period*** means a calendar year or that portion of a calendar year during which the Covered Person is covered under this Plan.

***COBRA*** means the amendments made to ERISA by the Consolidated Omnibus Budget Reconciliation Act of 1985, and regulations thereunder, as amended from time to time.

***Code*** means the Internal Revenue Code of 1986, and regulations thereunder, as amended from time to time.

***Coinsurance*** means that percentage of covered medical Expense, the payment of which is shared by the Fund and the claimant.

***Contributing Employer or Employer*** means an employer who has signed a collective bargaining agreement or other written agreement requiring the employer to make contributions to the Fund or who is required by law to contribute to the Fund on behalf of its Employees.

***Co-payment*** means the dollar amount of Covered Expenses that are required to be paid by a Covered Person under the terms of this Plan of benefits. Usually Co-payments are made directly to the provider of service.

***Covered Expense*** means any ***Medically Necessary Customary Charge*** for medical care, at least a portion of which is covered under at least one of the Health Plans covering the person for whom a claim is made. The difference between the cost of a private and semi-private Hospital room is not considered a ***Covered Expense*** unless ***Medically Necessary***. When a Health Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered both a ***Covered Expense*** and a benefit paid. Benefit payable by another Health Plan will be viewed as a benefit paid, whether or not a claim is filed under the plan.

***Covered Person*** means a Participant and his or her eligible Dependent(s).

***Custodial Care*** means care that consists of services and supplies furnished primarily to help a person in the activities of daily living and that does not require the continuous attention of trained medical/paramedical personnel. Such care may involve preparation of special diets, supervision over medication that may be self-administered, assistance in getting in or out of bed, walking, bathing, dressing, eating, and using the toilet. Such services are Custodial Care regardless of the practitioner or provider who prescribed, recommended or performed them.

***Customary Charge or Usual & Customary Charge*** means charges for medical care, services or supplies Medically Necessary to your care, to the extent that it does not exceed the general level of charges being made by providers of similar training and experience in the locality where the

charge is incurred when furnishing customary treatment for a similar Sickness, condition or Injury. The term "locality" means a county or such greater area as necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services, or supplies for which the charge was made. The Customary Charge payable will not exceed the maximum amounts set forth in the Schedule of Benefits adopted by the Board of Trustees.

***Dependent(s)***

(a) **In General. Dependent(s)** means the legal spouse of the opposite sex and each child under the age of 26 up until the end of the month during which such child attains age 26.

"Child" includes natural child, stepchild, adopted child, child placed with you for adoption, foster child and child for whom you have been duly appointed as the legal guardian. Dependent also includes someone who is provided coverage under this Plan pursuant to a Qualified Medical Child Support Order.

(b) **Dependents with Disabilities**. An unmarried child who has attained age 26 will continue to be an eligible Dependent, if:

(1) the child is handicapped and remains incapable of self-sustaining employment by reason of mental retardation or physical handicap;
(2) acceptable evidence of such incapability is furnished to the Fund with respect to any such child within 31 days after the later of: (a) the child attaining age 26, or (b) the Eligible Employee receiving notice of such handicap; and
(3) proof of such incapability is furnished to the Fund for time to time at the Fund's request.

(c) **Multiple Coverage under the Plan.** In the event that both parents are Participants, then such child will be considered a Dependent of one of the parents, but not both.

***Employee*** means a person who is hired on or after July 1, 2016 by a Contributing Employer

***ERISA*** means the Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

***Expense*** means a charge a Covered Person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

***Experimental*** means the use of treatment, procedures, facilities, equipment, drugs, medical or pharmaceutical agents, devices or supplies not yet generally recognized as accepted medical practice and any such services, facilities, equipment, drugs or supplies requiring federal or other government agency approval and for which such approval has not been granted at the time the services were rendered.

***FMLA*** means the Family and Medical Leave Act of 1993, and regulations thereunder, as amended from time to time.

***Fund*** means the Building Trades Welfare Benefit Fund established under the Fund's Trust Agreement, as may be amended or restated.

***Health Plan*** means any plan providing benefits or services for medical/dental treatment, when such benefits or services are provided by (a) group insurance coverage, (b) an employer-sponsored Blue Cross, Blue Shield, or other prepayment coverage, (c) any coverage under labor-management trusteed plans or employee benefits organization plans, including this Plan, (d) any coverage under governmental programs, (e) any coverage required or provided by statute (except Medicaid), (f) any mandatory "no-fault" coverage. Health Plan does not include a state plan under Medicaid; benefits under a law or plan when its benefits by law are excess to any private insurance plan; individual or family coverage except as described above; Medicare with respect to an actively employed Covered Person or spouse; disabled Covered Person; or school accident coverage. Dental Expenses will be coordinated only with like coverage from another Plan.

The term ***Health Plan*** will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract, or other arrangement which reserves the right to take the benefits and that portion which does not reserve such right.

***Hospital*** means an establishment that meets all of the following requirements: (1) holds a license as a hospital (if licensing is required in the state); (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (3) provides twenty-four (24) hour-a-day nursing service by registered or graduate nurses on duty or call; (4) has a staff of one or more licensed Physicians available at all times; (5) provides organized facilities for diagnosis and surgery either on its premises or at an institution with which the establishment has a formal arrangement for the provision of such facilities; and (6) is not primarily a clinic, nursing, rest or convalescent home or an extended care facility or a similar establishment and is not (other than incidentally) a place for treatment of alcoholism or drug addiction. Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home or an extended care facility is deemed with respect to the coverage provided by the Plan to be confinement in an institution other than a Hospital.

The term ***Hospital*** also includes a licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The types of procedures performed must permit discharge from the Center the same" working day." The Center will not qualify as a ***Hospital*** if:

1. Its primary purpose is performing abortions;

2. It is maintained as an office by a Physician for the practice of medicine; or

3. It is maintained as an office for the practice of dentistry.

***Injury*** means bodily injury caused by an accident resulting in loss, caused directly by such accident and independently of all other causes in loss covered by the Plan.

***Intensive Care Unit*** means an accommodation that is a segregated section within a Hospital which is specifically designed, permanently equipped and operated exclusively to provide extensive care for critically ill or injured patients and provides special supplies, equipment and constant audiovisual observation and care by registered nurses (R.N.'s) or other Hospital personnel as prescribed by the attending Physician. It does not include any facility maintained for the purpose of providing normal post-operative recovery treatment or service.

***Maintenance Drug*** means a drug prescribed by a Physician for on-going, day-to-day treatment of a condition which is expected to last more than thirty (30) days. Examples of Maintenance Drugs covered by the Plan include, but are not limited to, prescriptions requiring compounding and insulin. For current information about Maintenance Drugs covered by the Plan, contact Express Scripts at (800) 417-8164.

***Medically Necessary*** means a medical or dental treatment that is required to identify or treat the Sickness or Injury that a Physician has diagnosed or reasonably suspects. The service must be consistent with currently accepted medical or dental practice and with the diagnosis and treatment of the condition, be in accordance with local standards of good medical practice, be required for reasons other than the person's or the Physician's convenience and be performed in the least costly setting required by your condition, and is not Experimental in nature. A treatment is not Medically Necessary just because it is recommended by your Physician or Dentist.

***Medicare*** means benefits under Title XVIII of the Social Security Act of 1965, as amended from time to time.

***Participant*** means an Employee on whose behalf contributions are made to the Fund and who has satisfied the Plan's eligibility rules.

***Physician*** means a licensed doctor of medicine and acting within the scope of his or her license including a licensed chiropractor, who is not a Covered Person or a member of a Covered Person's immediate family (spouse, children, brothers, sisters, or parents of Covered Person).

***Plan*** means this booklet, which describes the Plan of benefits of the Fund as it may be modified or amended from time to time.

***Plan Quarter*** means August 1 – October 31, November 1 – January 31, February 1 – April 30, or May 1 – July 30.

***Proof of Loss*** means the completed claim form along with all original, itemized bills or other documents required under the Plan, signed and certified by the claimant or, in the case of death, the deceased's beneficiary.

***Qualified Medical Child Support Order*** or ***QMCSO*** means a medical child support order which creates or recognizes the existence of a child's right to, or assigns to a Child the right to, receive

benefits for which a Participant or Beneficiary is eligible under this Plan, and which complies with certain rules and regulations of ERISA, the Code and the Plan.

***Room and Board*** means all charges commonly made by a Hospital on its own behalf for a room and meals and for general services and activities essential to the care of bed patients.

***Separate Surgical Procedures*** means two or more necessary surgical procedures performed on the same day through the same incision and that are due to different and unrelated causes.

***Sickness*** means a non-occupational illness, condition or disease that requires treatment by a Physician and that causes a loss covered by the Plan.

***Skilled Nursing Facility*** means a facility which mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. The facility must carry out its stated purpose under all relevant state and local laws and is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare. In some places, a Skilled Nursing Facility may be called an "Extended Care Center" or a "Skilled Nursing Center."

***Successive Periods of Confinement or Successive Surgical Procedures*** means two or more periods of Hospital confinement or surgical procedures due to the same or related causes and shall be considered one confinement or procedure unless (a) with respect to the Participant only, such Participant has returned to Covered Employment for at least one (1) full working day before the subsequent confinement or procedure begins, or (b) with respect to a Dependent only, they are separated by three (3) months or more.

***Total Disability*** means inability to perform any of the substantial and material duties of the disabled person's occupation or employment. A child is deemed to be totally disabled if, as the result of Injury or Sickness, he or she is confined to the house or in a Hospital. A Dependent spouse is deemed to be totally disabled if, as the result of Injury or Sickness the spouse is unable to perform any of the regular routine activities normally performed by the spouse.

***Trustees*** **means** the members of the Board of Trustees of the Fund.

***USERRA*** means the Uniformed Services Employment and Reemployment Rights Act of 1994, and regulations thereunder, as amended from time to time.

## GENERAL LIMITATIONS AND EXCLUSIONS

Each particular benefit section of this Plan will contain limitations and exclusions applicable to that particular benefit. In addition, listed below are limitations, exclusions, and circumstances applicable to all sections which may cause denial or delay of benefit payment:

(a) (1) Covered Person was not eligible for the benefits claimed.
(2) Covered Person failed to apply or make timely application for benefits.
(3) Covered Person failed to submit required evidence to substantiate claim.
(4) Covered Person made material misstatements in connection with eligibility of the claim.
(5) Covered Person omitted facts or material statements as to other coverage available for the claim.
(6) Covered Person failed to seek relief under Worker's Compensation Laws, No-Fault Automobile Insurance, or similar legislation.
(7) The Employee's Contributing Employer fails to make timely contributions as required.

(b) No benefits will be paid by the Fund for charges or Expenses:

(1) Incurred as result of an Injury or Sickness arising out of or in the course of employment if (1) coverage is afforded under Worker's Compensation Laws or similar legislation, or (2) if the Covered Person receives compensation from the Contributing Employer for such Injury or Illness, whether by judgment, settlement or compromise; or (3) the Board of Trustees determines that the Injury or Illness arises out of employment.

(2) Which are not consistent with the diagnosis and treatment of the particular condition.

(3) Incurred unless performed or prescribed as Medically Necessary by a Physician, Dentist or licensed Psychologist.

(4) For which mandatory No-Fault Automobile Insurance is payable.

(5) In connection with an accidental Injury sustained while driving an uninsured vehicle.

(6) In connection with Sickness or Injury incurred in, or as the result of, declared or undeclared war, rebellion, revolution, military service or civil disturbance.

(7) For any and all Expenses incurred as a result of Pregnancy of a person covered as a Dependent child under this Plan.

(8) Coverage for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

(9) Declared or undeclared war; or act of war;

(10) Expenses which are not approved by a Physician;

(11) Cosmetic surgery. This does not apply to

a) Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or

b) Reconstructive surgery because of a congenital disease or anomaly of a Covered Person.

c) Reconstructive surgery to the extent required by applicable law.

(12) Eye examinations;

(13) Glasses or contact lenses;

(14) Charges made by a health care provider if related to the Covered Person or living with the person requiring treatment;

(15) Expenses for medical treatment of temporomandibular joint disturbances;

(16) Surgery to the eye for refractive purposes;

(17) Educational training, equipment or supplies, except those mandated by law;

(18) Surgical procedures or treatment to alter a person's sex;

(19) Intentionally self-inflicted Injury or Sickness that is not the result of a medical condition;

(20) Treatment of Infertility

(21) Dental care and treatment;

(22) Treatment determined to be Experimental or Investigational, except to the extent required by law;

(23) Hearing aids;

(24) Hospice Care;

(25) Acupuncture;

(26) Chiropractic Care;

(27) Blood and blood products;

(28) Biofeedback;

(29) Cardiac Therapy;

(30) Organ Transplants;

(31) Orthotics and Prosthetics

(32) Convalescent/Custodial Care;

(33) Respiratory Care;

(34) Substance Abuse Treatment or Counseling;

(35) Wigs or Hair Replacement;

(36) Mental Health Treatment;

(37) Care provided to you or your eligible Dependent(s) to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your eligible Dependent(s) in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your Dependent(s) may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, as provided in the "Subrogation and Reimbursement" and "Right of Recovery" sections on pages 59-61 of this SPD;

(38) Injections that are not considered preventative care under the ACA.

Any Expense incurred with respect to drugs or medicines that are covered in whole or in part under the "Prescription Drug Benefit" will not be considered as a Covered Expense under any other section. Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

## HOSPITAL EXPENSE BENEFIT

If, as a result of Sickness or Injury, a Covered Person is confined to a Hospital, the Fund will pay the following Customary Charge, subject to the applicable Coinsurance and Co-payments specified in the Schedule of Benefits.

For in-patient, out-patient and ambulatory surgical services, if you are treated at an in-network Hospital, in-network out-patient facility or an in-network ambulatory surgical center and in the course of receiving services, you are treated by an out-of-network (non-participating) surgeon, assistant surgeon, pathologist, radiologist or ambulance through no fault of your own, the cost of such services will be paid at 80% of the Usual & Customary Charge.

## Room and Board Benefit

A Room and Board benefit shall be payable in the amount of the daily Expenses incurred for Hospital room, board and general nursing care subject to a $250 Co-payment per stay. For services at an out-of-network Hospital in non-emergency situations, the Fund will pay 80% of the Usual & Customary Charge.

## Miscellaneous Hospital Expense Benefit

A Miscellaneous Expense benefit shall be payable in the amount of the Covered Expenses, subject to a $250 Co-payment at in-network Hospital and 80% of the Usual & Customary Charge at an out-of-network Hospital (provided that they are Medically Necessary) during a period of Hospital confinement for which the Room and Board benefit is payable for:

1. Hospital services and supplies;

2. Transportation in an ambulance to or from the Hospital; and

3. Tests or X-rays for diagnostic purposes within the seven days immediately preceding a period of Hospital confinement, provided that (1) the tests are in connection with the Sickness or Injury from which the confinement results, (2) the tests would be covered, if performed during Hospital confinement, (3) the tests are administered in the Hospital in which confinement immediately follows, (4) the confinement is determined to be Medically Necessary before the administration of the tests or X-rays, and (5) tests would have been covered if done as an in-patient. There is a $50 Co-payment for Pre-surgical testing with an in-network provider.

## In-patient Physical Therapy, Physical Medicine and Rehabilitation

The Fund will cover 100% of the preferred provider option ("PPO") rate for in-patient physical therapy, physical medicine and rehabilitation rendered at a participating facility, subject to a $250 Co-payment. For treatment rendered at an out-of-network facility, the Fund will pay 80% of the Usual & Customary Charges. Coverage will be provided for a maximum of 30 days in each calendar year. This maximum is combined with, and not in addition to, the maximum for all in-patient Hospital confinements, including confinement at a Skilled Nursing Facility. In addition, benefits are provided only when such services are performed under a program approved by the New York State Department of Health and only when the therapeutic confinement follows immediately from an eligible Hospital confinement and for which benefits were paid under this Plan.

## Skilled Nursing Facility Benefit

The Fund will cover 100% of the PPO rate for treatment rendered at a participating Skilled Nursing Care Facility, subject to a $250 Co-payment. The Fund will not cover services at an out-of-network facility. Coverage will be provided for a maximum of 30 days in each calendar year. This annual maximum is combined with, and not in addition to, the annual maximum for

all in-patient Hospital confinements, including confinement at a physical therapy, physical medicine and rehabilitation facility. In addition, the following conditions must be met in order for treatment at a Skilled Nursing Care Facility to be covered under the Plan:

- The Covered Person requires skilled nursing care treatment and pre-certification is obtained;
- The Covered Person is transferred to the Skilled Nursing Care Facility within seven days of being discharged from a Hospital for which benefits were covered under this Plan; and
- The treatment provided at the Skilled Nursing Care Facility is consistent with the diagnosis and treatment of the condition that required the preceding in-patient Hospital confinement and such Hospital confinement was for at least 3 consecutive days.

**Out-Patient Benefits**

Even though a Room and Board benefit may not be payable, a benefit shall be payable for Covered Expenses incurred for Hospital out-patient emergency medical services consistent with the requirements of applicable law.

A benefit shall be payable for out-patient services rendered within seventy-two (72) hours after (and as a direct result of) an Injury.

The full Hospital Expense Benefit, as set forth in the Schedule of Benefits, will be available for each period of Hospital confinement that is not a Successive Period of Confinement, as defined at page 5.

**Limitations and Exclusions**

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for loss caused by or resulting from Hospital confinement or service which is not approved by a Physician.

**Preventive and Primary Care Services**

**Preventative Care**

The Fund covers a number of preventive care services without any cost-sharing (Co-payment, Co-insurance) for you or your dependents. These services include annual physical exams and certain screenings, tests, vaccines, to the extent such services are included on the government's lists below, provided the services have been included on the list for at least one year prior to the Fund's Plan year. For example, if a preventive service was added to one of the lists in September 2015, it would be covered with no cost-sharing beginning January 1, 2017. The applicable lists are:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B;
- Recommended Immunizations of the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention; and
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

You can access these lists at www.healthcare.gov.

To the extent a recommended preventive service is provided as part of a regular office visit with your provider, the applicable out-of-pocket expenses for office visits under the Plan will still apply to the extent permitted by law. However, you will not be responsible for any additional amounts with respect to any of the preventive services referenced in the lists above if you use a provider that participates in the BCBS Network.

**Please note that the lists of preventive services include certain age, frequency, and other limitations that may affect your ability to receive coverage for the service without cost sharing. If you do not satisfy these limitations, you may incur out-of-pocket expenses.**

**Well-Child Care**

A child who is a Covered Person is entitled to coverage for Child Preventive and Primary Care Services from the moment of birth to age 19 years. Such services shall be exempt from any Co-payment or Co-insurance.

**"Child Preventive and Primary Care Services"** means an initial Hospital check-up and well-child visits as scheduled in accordance with the prevailing clinical standards of a national association of pediatric Physicians designated by the Commissioner of Health when delivered, supervised, prescribed or recommended by a Physician.

## MATERNITY LENGTH OF STAY

Group health plans and health insurance issuers offering group insurance coverage 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

## HOME HEALTH CARE EXPENSE BENEFIT

If a Covered Person incurs Home Health Care Expenses, the Fund will pay, at the rate shown in the Schedule of Benefits and up to the maximum visits, the Home Health Care Expenses which are the result of a Sickness or Injury, and constituted Necessary Treatment.

### Home Health Care Expenses

The charge must be made for services furnished in the patient's home by an in-network Home Health Care Agency, and in accordance with a Home Health Care Plan.

To the extent that they are Customary, the above charges are Home Health Care Expenses if they are for:

1. Part-time or intermittent nursing care by or under the supervision of a R.N.;
2. Visits by persons who have completed a Home Health Aide training course. The visit must be under the supervision of a Registered Nurse;
3. The following therapy:
    a. Physical
    b. Occupational; and
    c. Speech
4. Medical supplies, drugs and medications prescribed by a Physician;
5. Laboratory services, to the extent such items would have been covered if the Covered Person had been in a Hospital.

Each visit by a member of a home health care team is considered as one home health care visit. Four hours of home health aide service is considered as one home health care visit.

### Limitations and Exclusions

No benefits are payable for:

1. Transportation services;
2. Any period during which the Covered Person is not under the care of a Physician;
3. Any visit for which Medicare has determined Home Health Care is unnecessary for the Covered Person.

4. No benefits are payable with respect to any Expenses incurred for a home health care visit which is covered in whole or in part under Medicare.

## SURGICAL EXPENSE BENEFIT

If, as a result of Sickness or Injury, a Covered Person undergoes a Medically Necessary surgical procedure at an in-network facility, the Fund will pay a Surgical Expense Benefit for Customary Charges up to the amount shown in the Schedule of Operations for any procedure, subject to a Co-payment of $250. At an out-of-network facility, the Fund will cover 80% of the Usual and Customary Charges.

Surgical Expenses include the anesthesiologist's fees in connection with the procedure.

### Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for loss caused by or resulting from any of the following:

1. Any surgical procedure which is not approved by a Physician, or

2. Surgery in connection with dental care and treatment, except that made Medically Necessary by Injury.

## ADDITIONAL SURGICAL OPINION

If an operation is recommended to treat a Sickness or Injury, the Covered Person may want to obtain additional surgical opinions as to its need prior to the operation. For information on how to obtain an additional surgical opinion, please refer to the Pre-Certification/Managed Care and Second Surgical Opinion procedures beginning on page 2 of this Summary Plan Description. If such additional surgical opinions are secured from a Board Certified Specialist in the surgical or medical specialty for which surgery is proposed and who has examined the patient in person, the Fund will pay 100% of the cost with an in-network surgeon, subject to a $40 Co-payment and 80% of the Usual and Customary Charges for an out-of-network provider.

This benefit will be payable only if the claim submitted is based on a written report from the Specialist. Benefits are not payable if the Specialist giving the opinion also performs the surgical procedure.

## WOMEN'S HEALTH AND CANCER RIGHTS ACT

Federal law provides that any group health plan that provides medical and surgical benefits with respect to a mastectomy, must also provide coverage for reconstructive surgery following the mastectomy as follows:

- reconstruction of the breast on which the mastectomy was performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and physical complications of all stages of mastectomy, including lymphedema.

Such benefits are subject to the Plan's Deductibles and Coinsurance provisions.

## SCHEDULE OF OPERATIONS

| PROCEDURE: | AMOUNT OF PAYMENT |
|---|---|
| **ABDOMEN** | |
| Appendectomy | $1,000.00 |
| Removal of or other operation on gall bladder | 1,500.00 |
| Gastroenterostomy | 1,500.00 |
| Resection of stomach, bowel or rectum | 2,000.00 |
| **ABSCESS** | |
| Incision and Drainage (simple) | 100.00 |
| **AMPUTATIONS** | |
| Thigh, leg | 1,250.00 |
| Upper arm, forearm, hand or foot | 1,000.00 |
| Fingers or toes, each | 150.00 |
| **BREAST** | |
| Removal of benign tumor or cyst requiring Hospital residence | 500.00 |
| Simple amputation | 1,000.00 |
| Radical amputation | 1,500.00 |
| **CHEST** | |
| Complete thoracoplasty, transthoracic approach to stomach, diaphragm, or esophagus, sympathectomy or laryngectomy | 2,000.00 |
| Removal of lung or portion of lung | 2,000.00 |
| Bronchoscopy, escophagoscopy | |
| Diagnostic | 400.00 |
| Operative | 500.00 |
| Induction of artificial pneumothorax | |
| Initial | 250.00 |
| Refills, each (not more than 17) | 100.00 |
| **DISLOCATION, REDUCTION OF** | |
| Hip, ankle joint, elbow or knee joint (patella excepted) | 350.00 |
| Shoulder | 250.00 |

Lower jaw, collar bone, wrist, patella.....150.00

For a dislocation requiring an open operation, the maximum will be 2 times the amount shown above.

**EXCISION OR FIXATION BY CUTTING**

Hip joint.....1,500.00
Shoulder, Semilunar cartilage, knee, elbow, wrist, ankle joint.....1,000.00
Removal of diseased portion of bone, including curettage (alveolar processes excepted).....500.00

**EAR, NOSE OR THROAT**

Fenestration, one or both ears.....2,000.00
Mastoidectomy, one or both sides
Simple.....1,000.00
Radical.....1,500.00
Tonsillectomy, adenoidectomy, or both.....300.00
Sinus operation by cutting (puncture of antrum excepted).....500.00
Submucous resection of nasal septum.....500.00
Tracheotomy.....500.00

**EYE**

Operation for detached retina.....2,000.00
Cataract, removal of.....1,500.00
Any other cutting operation into the eyeball (through the cornea or sclera) or cutting operation on eye muscles.....1,000.00
Removal of eyeball.....750.00

**FRACTURE, TREATMENT OF**

Thigh, vertebra or vertebrae, pelvis (coccyx excepted).....750.00
Leg, kneecap, upper arm, ankle (Potts), skull.....500.00
Lower jaw
(alveolar process excepted), collar bone shoulder blade, forearm, wrist (Colles).....250.00
Hand or foot.....150.00
Fingers or toes, each.....100.00
Nose.....100.00
Rib or ribs
Three or more.....250.00
Less than three.....100.00

The amounts shown above are for simple fractures.

For a compound fracture the maximum payment will be 1 ½ times the amount shown above for the corresponding simple fracture.

For a fracture requiring an open operation, the maximum payment will be twice the amount shown above for the corresponding simple fracture (bone grafting or bone splicing and skeletal traction pin are considered as open operations).

**GENITO-URINARY TRACT**

Removal of or cutting into kidney ..... 2,000.00
Fixation of kidney ..... 1,500.00
Removal of tumors or stones in ureter or bladder
- By cutting operation ..... 1,000.00
- By endoscopic means ..... 350.00

Cystoscopy ..... 250.00
Removal of prostate by open operation ..... 1,000.00
Removal of prostate by endoscopic means ..... 670.00
Circumcision ..... 150.00
Varicocele, hydrocele, orchidectomy or epididymectomy
- Single ..... 500.00
- Bilateral ..... 750.00

Hysterectomy ..... 1,500.00
Cervix amputation ..... 500.00
Dilation and curettage (non-puerperal) ..... 250.00
Conization ..... 250.00
Polypectomy (one or more) ..... 250.00
Cauterization
- (where done separately and not in conjunction with any of the above procedures) ... 250.00

**GOITRE**

Removal of thyroid, subtotal ..... 1,500.00
Removal of adenoma or benign tumor of thyroid ..... 1,000.00

**HERNIA, REPAIR OF**

Single hernia ..... 1,000.00
More than one hernia ..... 1,250.00

**JOINT**

Incision into tapping excepted ..... 250.00

**LIGAMENTS AND TENDONS**

Cutting or transplant
- Single ..... 500.00
- Multiple ..... 750.00

Suturing of tendon
- Single ..... 350.00
- Multiple ..... 500.00

**PARACENTESIS**

Tapping ..... 150.00

**PILONIDAL CYST OR SINUS**

Removal of.....500.00

**RECTUM**

Colonoscopy or (procto) sigmoidoscopy

- Diagnostic.....100.00
- With biopsy.....150.00
- With removal of polyp or polyps.....150.00

Hemorrhoidectomy

- External only.....250.00
- Internal only or internal and external.....500.00

Cutting operation for fissure.....250.00

Cutting operation for thrombosed hemorrhoids.....150.00

Cutting operation for fistula in ano

- Single.....500.00
- Multiple.....750.00

**SKULL**

Cutting into cranial cavity (drill taps excepted).....2,000.00

Drill taps.....250.00

**SPINE OR SPINAL CORD**

Operation for spinal cord tumor.....2,000.00

Operation with removal of portion of vertebra or vertebrae (except coccyx).....1,500.00

Removal of part or all of coccyx.....500.00

**TUMORS, EXCISION OF**

Benign or superficial tumors and cysts or abscesses

- Requiring Hospital residence.....250.00
- Not requiring Hospital residence.....100.00

Malignant tumors of face, kip or skin.....500.00

**VARICOSE VEINS**

Injection treatment, complete procedure.....400.00

Cutting operation, complete procedure

- One leg.....500.00
- Both legs.....800.00

**OBSTETRICAL PROCEDURES**

Normal delivery.....1,000.00

Caesarean section.....2,000.00

Extra-uterine pregnancy.....1,200.00

Miscarriage.....500.00

## MEDICAL EXPENSE BENEFIT

If as a result of Sickness or Injury a Covered Person requires medical treatment by a Physician, the Fund will pay the amounts indicated in the Schedule of Benefits toward the Physician's fee. All such payments are subject to the limitations noted in the Schedule of Benefits.

### Successive Treatments by a Physician

Successive treatments by a Physician due to the same or related causes will be considered as resulting from one Sickness or Injury unless:

1. Separated by a period of 3 months or more; or

2. In the case of an active Employee, the treatments are separated by a return to work on a full-time basis for a least 1 day;

and will be covered only if the Medical Expense Benefit is then in force as to the Covered Person.

### X-Ray and Diagnostic Expense Benefit

If you (while not Hospital confined) incur Expenses as a Covered Person for laboratory tests or X-rays for the diagnosis of a Sickness or Injury, including the interpretation of such tests, the Fund will pay for these Expenses under the terms of this Plan, but not more than the Customary Charges made for such services. Charges for the interpretation of such tests or X-rays also will be covered under this benefit.

Charges for diagnostic laboratory tests or X-rays otherwise covered under the Hospital Expense Benefit section of this Plan will not be covered under this section of the Plan.

## X-RAY AND RADIOACTIVE THERAPY EXPENSE BENEFIT

If a Covered Person, while covered, and in connection with the Necessary Treatment of a condition undergoes:

1. X-ray treatment;

2. Radium treatment; or

3. Radioactive isotope treatment

we will pay the excess, if any, of the fee charged by the Physician for such treatment over the amount of any Medical Expense Benefits payable under the policy. The maximum payable will not exceed:

1. The maximum specified for the treatment in the Schedule of X-ray and Radioactive treatments; nor

2. The maximum stated in the Schedule of Benefits.

## SCHEDULE OF X-RAY AND RADIOACTIVE TREATMENTS

| Condition Treated | Maximum Amount of Payment Per Treatment |
|---|---|
| TELERADIOTHERAPY, including roentgen ray, teleradium, telecobalt, telecesium, betatron, etc. | $15.00 |
| X-RAY THERAPY-less than 1,000 KVP and Telecesium | |
| Testicle | 15.00 |
| Uterine cervix | 15.00 |
| Breast, primary, inoperable | 15.00 |
| Recurrence of metastasis | 15.00 |
| Skin | 30.00 |
| Lip | 30.00 |
| Other neoplasm | 15.00 |
| SUPER-VOLTAGE X-RAY 1,000 kvp and higher | |
| Cobalt, betatron | 20.00 |
| RADIUM AND RADIOISOTOPES (sealed sources), intracavity, interstitial plaque or mold | |
| Testile | 225.00 |
| Uterine cervix | 175.00 |
| Breast, primary, inoperable | 175.00 |
| Recurrence of metestasis | 150.00 |
| Skin | 75.00 |
| Lip | 75.00 |
| Other neoplasm | 150.00 |
| RADIOISOTOPES (non-sealed sources) administered internally | |
| Thyroid cancer | 150.00 |
| Ascites and pleural effusion due to malignancy | 100.00 |
| Metastic carcinoma of bone | 100.00 |
| Chronic leukemia | 100.00 |
| Prostatic cancer | 150.00 |

If two or more treatments are given on the same day; the total amount payable for all of them will not exceed the benefit for the condition which has the largest maximum allowance.

If a Covered Person, while a Hospital out-patient, receives a treatment for which benefits are payable and the Physician's fee is included in the charge made by the Hospital; that part of the Hospital charge representing the Physician's fee will be recognized as a basis for a claim to the same extent as though such charge had been made by the Physician.

### Limitations and Exclusions

No benefits under this section are payable for Expenses incurred for diagnostic purposes or for the rental or purchase of radioactive substances. There is no out-of-network coverage, except for radiation treatment, which is covered at 80% of the Usual and Customary Charge.

## PRESCRIPTION DRUG BENEFIT

The Fund's prescription drug benefit program is administered by American Health Care (AHC). Subject to the provisions of this Section and other applicable limitations and exclusions described in this document, the Fund will cover the cost of prescription drugs, minus the applicable Co-payment.

The Plan's Co-payment for prescriptions filled at a retail pharmacy for generic drugs is $10.00 per prescription, for brand name drugs is $25.00 per prescription and for non-formulary drugs is $35 per prescription. You can fill your prescription at any retail pharmacy that participates in AHC's pharmacy network. To locate a participating pharmacy in your area, you can log onto AHC's website at www.americanhealthcare.com or contact AHC's Member Services help desk at (800) 872-8276. The Fund will not cover the cost of any prescription that is filled at a pharmacy that does not participate in the AHC pharmacy network so please make sure you verify that your pharmacy participates in this network.

In order to receive coverage for your prescription, make sure to provide your pharmacy with a copy of your prescription drug card that lists AHC as your prescription drug provider. If you fail to provide your card at the time your prescription is filled, the pharmacy may charge you for the full cost of the prescription and any subsequent reimbursement from the Fund will be limited to the amount the Fund would have paid for that prescription under its arrangement with AHC, minus the Co-payment, even if you paid more for the prescription. If you have questions regarding whether a medication is covered, please contact AHC at 1-800-872-8276.

### Quantity Limitations, Pre-authorization, Step Therapy and Other Limitations

Prior Authorizations

Certain drugs and drug classifications require prior authorization before the Fund will cover that drug. Prior authorization helps to ensure that the prescribed drug is the most appropriate medication to treat your condition. All prior authorizations will be reviewed by a clinical

pharmacist at AHC based on pre-established medical criteria and follow-up with the prescriber. The following claims are subject to prior authorization:

- Any drug that exceeds $500 for a 30-day supply;
- Any drug that exceeds $1,500 for a 31-90 supply;
- Compound medications that exceed $250;
- Drugs designated by AHC to be subject to prior authorization;
- Replacements for lost or stolen medications; and
- Requests for an additional supply because of travel.

If you are taking a prescription that requires prior authorization, AHC will automatically address that at the time your claim is submitted by the pharmacy. If your claim is denied based on the prior authorization review, you will be notified of that determination and you can appeal that determination to the Fund's Board of Trustees pursuant to the claims and appeals rules described beginning on page 62 of the SPD.

Quantity Limits

Quantity limits are placed on certain medications to ensure effectiveness, safety, and appropriate usage of the medication. The quantity limit is the maximum amount of a particular medication that can be provided to a Covered Person during a given amount of time. If a medication is prescribed over the standard maximum limit for that drug, a prior authorization will need to be completed. If the prior authorization is denied, the Fund will only cover the prescription up to the maximum quantity limit for that medication. For a list of drugs that are subject to quantity limits, please contact AHC.

Step Therapy

Step therapy is a process used to ensure that the most effective, safe, and least costly medications are tried first before moving on to other medications. If you submit a prescription for a drug that is subject to AHC's step therapy program, an AHC clinician will contact the prescriber to determine if there is a medical reason that you cannot take a drug on a "lower step" than the one prescribed. If the prescriber agrees, your prescription will be filled consistent with the Fund's step therapy program. If you have any questions about whether a particular drug is subject to a step therapy program or how that program works, please contact AHC.

Other Limitations

Many brand drugs have a generic equivalent that is required to have the same quality, strength, and purity as the brand drug. Therefore, if you receive a prescription for a brand drug that has a generic equivalent, the pharmacist will fill the prescription using the generic equivalent. If you request that the brand drug be provided instead, the Fund will cover the cost of the brand drug up

to the amount it would have paid for the generic equivalent and you will be required to pay the difference, in addition to the applicable Co-payment, unless the prescriber requires that you receive the brand drug, in which case the Fund will cover the brand drug subject to the other requirements of this Section.

**Mail Order Services**

You can, but are not required to, refill prescriptions for maintenance drugs through the Fund's mail order pharmacy. Through the mail order service, you will receive a 90-day supply subject to a Co-Payment of $20 for generic drugs, $50 for brand drugs and $70 for non-formulary drugs. The medication will be shipped directly to the address you choose. If you wish to refill your maintenance drug prescription by mail, your prescription can be filled through the preferred mail-order pharmacy, Catamaran Home Delivery. It is recommended that you have your physician write an updated prescription of your medication so that you can send it to Catamaran Home Delivery. However, if you are unable to obtain an updated prescription, you can have your refills transferred to Catamaran by contacting Catamaran Home Delivery at (800) 881-1966 and providing your previous mail service pharmacy information. Additional information can be found online at www.mycatamaranRx.com.

Limitations and Exclusions

In addition to the limitations described in this Section and the Limitations and Exclusions applicable to all forms of benefits, no benefits are payable for the following:

- Drugs used for cosmetic purposes, except that injectables (e.g., Botox) will be covered if medically necessary based on a prior authorization review;
- Depigmentation products used for conditions requiring bleaching agent;
- Drugs used to treat impotence;
- Weight management drugs;
- Immunizations administered at a pharmacy with the exception of the influenza vaccine;
- Vitamins other than prenatal vitamins or as otherwise required by law;
- Fluoride products for Covered Persons over the age of 16;
- Insulin pumps and related supplies;
- Allergy Serums;
- Unauthorized refills;
- Items lawfully obtainable without prescription;

- Any charge for the administration of a drug or insulin;
- Genetically Engineered drugs, including all growth hormones;
- Medication for a Covered Person confined to a rest home, nursing home, sanitarium, extended care facility, Hospital or similar entity;
- Any charge above the Customary, advertised or posted charge, whichever is less than the scheduled amounts;
- Devices and Appliances;
- Investigational or Experimental drugs, except as required by law;
- Immune Altering drugs;
- Prescriptions covered without charge under Federal, State or Local programs, including Worker's Compensation;
- Drugs not approved during the prior authorization process;
- Fertility drugs;
- Specialty Drugs

## DEATH BENEFIT

In the event of the death of a Participant, the death benefit shown in the Schedule of Benefits will be paid to the deceased person's beneficiary pursuant to an insurance contract issued by the Hartford Life Insurance Company.

It is very important that you designate the individual (beneficiary) to whom you wish your death benefit to be paid. You may name anyone you wish as your beneficiary and you may change your beneficiary designation as often as you like by completing the proper forms. These forms can be obtained by contacting the Fund Office. In the event that your beneficiary dies before you, the benefit will be paid pursuant to the provisions of the Policy.

Please refer to the booklet prepared by the Hartford Life Insurance Company for more details regarding this benefit. If there are any inconsistencies between the terms of this Plan and the Hartford Life Insurance Company booklet, the booklet will always control.

## ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

In the event of the accidental death of a Participant, or in the event a Participant sustains a purely accidental loss, the benefit payments will be provided through an insurance contract with the Hartford Life Insurance Company. Please refer to the booklet prepared by the Hartford Life Insurance for more details regarding this benefit.

## COBRA CONTINUATION COVERAGE

### History of COBRA

On April 7, 1986 a Federal law was enacted (Public Law 99-272, Title X), called the Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, allowing Participants and their Dependents to contribute to a temporary extension of health coverage (called "Continuation Coverage") at group rates in certain instances where coverage under the Welfare Plan would otherwise end.

### Qualifying Events

If any of the following events ("Qualifying Event") result in loss of benefits, the appropriate Covered Person will be offered the opportunity for a temporary continuation of benefits coverage at group rates, so long as the person was covered under the Plan on the day before the Qualifying Event:

(a) Participant's termination of employment, for reasons other than gross misconduct;

(b) Participant's reduction in hours of employment;

(c) Participant's entitlement to Medicare;

(d) Death of the Participant;

(e) Participant's divorce;

(f) Participant's legal separation;

(g) Loss of eligibility by a Dependent child.

An increase in premiums or contributions that must be paid by the Employee as a result of any of the above-listed events constitutes a loss of coverage and entitles the Covered Person to continuation coverage under COBRA.

### Reporting Requirements

The Participant's Employer must notify the Fund Office of the occurrence of any of the following qualifying events regarding the Participant: termination of employment; reduction of

working hours to less than twenty (20) hours per week; entitlement to Medicare; death of the Participant. This notification must be in writing and must be furnished within thirty (30) days of the occurrence of the qualifying event. Failure to provide such timely notification may subject the employer to serious Federal tax sanctions.

The affected Covered Person must notify the Fund Office in the event of divorce or legal separation from the Participant or loss of eligibility by a Dependent child. This notification must be furnished in writing within sixty (60) days of the occurrence of the qualifying event. Failure to furnish such notification within the required sixty (60) days may result in the loss of the right to Continuation Coverage.

### Reporting of Second Qualifying Event or Disability

Participants and Dependents covered under COBRA Continuation Coverage must provide written notice of a second Qualifying Event or Disability to the Fund Office within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month COBRA Continuation Coverage period. The written notice must conform to the requirements for providing notices in the section titled "Content of Notice." The notice must include evidence of the second Qualifying Event or disability (for example a copy of the: divorce decree, separation agreement, death certificate, Medicare eligibility/enrollment, Dependent's birth certificate, SSA disability determination).

### Financial Responsibility for Failure to Give Notice

If a Covered Person fails to give proper notice within sixty (60) days of the date of the Qualifying Event for which the Covered Person is responsible to give notice (see below), or a Contributing Employer within thirty (30) days of the Qualifying Event for which the contributing Employer is required to give notice (see below) and, as a result, the Plan pays a claim for a Covered Person whose coverage terminated due to a Qualifying Event and who does not elect continuation coverage under this provision, then the Covered Person or the Contributing Employer, as appropriate, shall be obligated to reimburse the Plan for any claims that should not have been paid. If a Covered Person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual and his or her Dependents.

If a Contributing Employer fails to give proper notice within thirty days of the Qualifying Event as required and the Covered Person is, as a result, permitted to elect, and does not elect Continuation Coverage more than ninety (90) days after the date of the Qualifying Event, the Employer shall be obligated to reimburse the Plan for all claims paid by the Plan on behalf of the Covered Person. The Trustees, in their sole discretion, may limit the application of this subsection where it appears, based on all circumstances, that the Covered Person would have elected Continuation Coverage within ninety days of the Qualifying Event had notice of the right to such an election been provided during the period.

In addition, a Participant or eligible Dependent must notify the Fund Office immediately if the Participant and/or Dependent become covered by any other plan of group health benefits whether

through employment or otherwise. The Fund must be repaid for any claims paid in error as a result of a failure to notify the Fund Office of any other health coverage.

**Notice and Election Form**

The Fund Office will, within ninety (90) days of the date a Participant or Dependent first becomes covered under the Fund, send a general notice regarding COBRA rights.

Participants and Dependents are required to notify the Fund Office in the event that they experience one of the following qualifying events:

(a) divorce or legal separation;

(b) a Dependent losing eligibility for coverage under the Fund; or

(c) the occurrence of a disability or a second qualifying event after becoming entitled to COBRA coverage.

The Participant or Dependent is required to notify the Fund Office within sixty (60) days of the later of the occurrence of a Qualifying Event described above or the date on which there is a loss of coverage as a result of the event. If a qualified beneficiary receives notice of disability determination by the Social Security Administration, the qualified beneficiary must give notice to the Fund Office of such determination within sixty (60) days of the later of the date the Social Security determination, the date on which the qualified beneficiary is informed of the obligation to provide notice of disability, or the date on which the qualified beneficiary loses or would lose coverage.

Notice to the Fund Office of a qualifying event is properly made when the Participant or Dependent writes to the Fund Office and indicates (1) the name of the Participant and/or Dependent who should be covered, (2) a description of the Qualifying Event, and (3) the date of the Qualifying Event. The Notice should also include any relevant documentary support.

Employers are responsible for sending the Fund Office notice in the event that an Employee experiences one of the following Qualifying Events:

(a) termination of employment;

(b) reduction in hours of employment;

(c) death of an Employee; or

(d) an Employee becomes entitled to Medicare.

The Fund Office will send within fourteen (14) days of the receipt of notification of the occurrence of a Qualifying Event, a COBRA Notice and Election Form. This form will describe the coverage options available, their costs and the conditions under which the Continuation Coverage will terminate. The Fund Office will also send a potential Covered Person who is <u>not</u>

entitled to receive COBRA coverage, notice that they will not be covered within fourteen (14) days after the occurrence of a purported qualifying event. This notice will describe why COBRA coverage is not available.

In order to obtain Continuation Coverage under the provisions of COBRA, the Notice of Election Form must be completed and returned to the Fund Office within sixty (60) days after receipt. Payment of the COBRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within forty-five (45) days after the return of the completed COBRA Notice and Election Form.

If the Covered Person qualifies for continued coverage under COBRA and elects to waive the coverage during the election period, the person may later elect COBRA coverage if done so before the end of the election period. However, if the coverage is initially waived and the waiver is later revoked during the election period, the plan is not required to provide coverage retroactively and is only required to provide coverage prospectively from the date the waiver is revoked.

**Content of Notice**

The written notice of a Qualifying Event or Second Qualifying Event must include the following information: name and address of affected Participant and or Dependent, Participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example: a copy of: the divorce decree, separation agreement, death certificate, Dependent's birth certificate, Dependent's adoption records). Once the Fund receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the Participant and Dependents, as applicable.

**Notice of Change of Participant's and Dependent's Address**

It is very important that Participants and Dependents keep the Fund informed of their current addresses. If you or a covered family member experience a change of address, immediately inform the Fund Office.

**Spousal Rights**

So long as the Dependent spouse of the Participant was covered under the Plan on the day before the Qualifying Event, the spouse will have the right to elect Continuation Coverage for himself or herself, if he or she loses coverage under the Plan for any of the following reasons:

1. the death of the Participant;

2. termination of the Participant's employment, other than for gross misconduct, or reduction in the Participant's hours of employment;

3. divorce or legal separation of the Participant; or

4. eligibility of the Participant for Medicare.

## Dependent Children's Rights

The Dependent child of a Participant who was covered under the Plan on the day before the Qualifying Event will have the right to choose Continuation Coverage for himself or herself, if he or she loses coverage under the Plan for any of the below listed reasons. A child who is born to or adopted by an Employee during the period of COBRA coverage is also a qualified Dependent child.

1. the death of the Participant;

2. termination of the Participant's employment, other than gross misconduct, or reduction in the eligible person's hours of employment;

3. divorce or legal separation of the Participant;

4. eligibility of the Participant for Medicare; or

5. the Dependent child's ceasing to satisfy the Plan's definition of a Dependent.

## Newborn or Adopted Children

If you have a child born, or if a child is placed for adoption with you, during a period of COBRA coverage, you may elect COBRA continuation coverage for that child for the remainder of your COBRA coverage period provided you enroll the child in accordance with the Plan's rules. Coverage for the newborn or adopted child will continue for the same time as coverage for Dependent children who were properly enrolled in the Fund on the day before the Qualifying Event. Newborn or adopted children added to your COBRA coverage also become qualified Dependents.

## Premium Payments

Continuation Coverage requires timely application for coverage and the timely payment of premiums. The premium due date for premiums subsequent to the initial premium is the first day of the month for which Continuation Coverage is sought. For example, premiums for the month of November must be paid on or before November 1. The initial premium due for the initial period of Continuation Coverage will include payment for the period of time dating back to the date on which Plan coverage terminated. Failure to pay the full premium by each due date (or within the thirty [30] day grace period thereafter, except that for the first month of COBRA, the grace period is forty-five [45] days) will result in a loss of all Continuation Coverage. A payment will be considered timely if it is postmarked no later than the due date.

Once a timely election of Continuation Coverage has been made, it is the responsibility of you and/or your Dependent(s) seeking Continuation Coverage to make timely payment of all required premiums. The Fund will not notify you and/or your Dependent(s) that a premium payment is due or is late. Further, the Fund will not notify you/or your Dependent(s) that Continuation Coverage is about to be, or has been, terminated due to the untimely payment of a required premium.

When a Qualifying Event, such as a divorce, causes a family to split into two units, then for purposes of calculating any applicable family (as opposed to individual) Deductible, each family unit is credited with the Expenses incurred by the members in that particular family unit who have elected COBRA coverage.

**COBRA Continuation Period**

Coverage may continue, on a self-pay basis, as follows:

(a) Coverage for you and/or your Dependent(s) may be continued for up to eighteen (18) months, if coverage terminated due to the Participant's:

1) termination of employment, other than for gross misconduct;

2) reduced work hours; or

3) retirement.

The eighteen (18) month period of Continuation Coverage starts from the date that your coverage is terminated as a result of the Qualifying Event and may be extended an additional eleven (11) months if at the time of the Qualifying Event described in (a)(1) or (a)(2) above, you or your Dependent are determined to be disabled by the Social Security Administration. Effective January 1, 1997, this disability extension is available if you or your Dependent are determined to be disabled at any time during the first sixty (60) days of Continuation Coverage. Proof of disability must be provided to the Fund within sixty (60) days of the date the Social Security Administration makes the determination and before the end of the eighteen (18) month Continuation Coverage period. The extended period of Continuation Coverage applies to you and your other Dependents, as well as the disabled person. If the Social Security Administration determines during the initial eighteen (18) month period that the person is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines after the initial eighteen (18) month period that the person is no longer disabled, the period of Continuation Coverage ends with the first month that begins more than thirty (30) days after the date of the Social Security Administration's determination, so long as the period of Continuation Coverage does not exceed twenty-nine (29) months.

(b) Coverage of your Dependent(s) may be continued for up to thirty-six (36) months from the date coverage terminates, if coverage terminated due to:

1) your death;

2) divorce or legal separation; or

3) with respect to your Dependent child, his or her ceasing to satisfy the Plan's definition of a Dependent.

(c) If your Dependent's coverage is continued for eighteen months as a result of a Qualifying Event listed in paragraph (a) of this section and, during the continuation period, a Qualifying Event occurs which entitles the Dependent to continue coverage under paragraph (b) of this section, your Dependent may elect to continue coverage up to a combined maximum of thirty-six (36) months. If a Qualifying Event under paragraph (b) of this section occurs during the 18-month continuation period, Dependent children added to your coverage during the continuation period may also elect Continuation Coverage up to a combined maximum of thirty-six (36) months. If your Dependents are covered under COBRA Continuation Coverage for 18 months because of your termination of employment or reduction in hours and you become entitled to Medicare benefits, your Medicare entitlement will not be considered a second qualifying event and your Dependents' COBRA coverage will not be extended for an additional 18-month period.

**Termination of COBRA Continuation of Coverage**

If you and/or your Dependent(s) do not elect Continuation Coverage, you and/or your Dependent's group health coverage will end in accordance with the plan provisions entitled "When Do Benefits Terminate?" beginning on page 11.

If you and/or your Dependent elect Continuation Coverage, the continuation coverage will cease on the ***first*** of the following dates:

(a) the date the Plan terminates;

(b) the date a required premium is due and unpaid after the applicable grace period;

(c) the date you and/or your Dependent(s) become covered under another group Health Plan as long as it is after the date you elected COBRA coverage. This may not apply if you and/or your Dependent have a pre-existing condition which is not covered under the new plan. However, effective on and after July 1, 1997 if the new plan has a pre-existing exclusion that does not apply to (or is satisfied by) you or your Dependent(s) because of a federal law restricting pre-existing condition exclusions, then Continuation Coverage under this Plan can be terminated. Contact the Fund for additional information when you and/or your Dependent(s) become insured under another group plan;

(d) the date you or your Dependent(s) first become eligible for Medicare, as long as it is after the date you elected COBRA coverage;

(e) the date the applicable period of Continuation Coverage is exhausted; or

(f) the first month that begins more than thirty (30) days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled, in situations where coverage was being extended for eleven (11) months, so long as the period of Continuation Coverage does not exceed twenty-nine (29) months.

(g) If your employer ceases to maintain any group Health Plan for its Employees through the Fund, the date your employer makes health coverage available to a class of Employees formerly covered under the Plan.

## Details of COBRA Continuation Coverage

If you choose Continuation Coverage, the health coverage provided is identical to the health coverage provided under the Plan to similarly situated Covered Persons. If the coverage provided under the Plan is modified after you elect Continuation Coverage, your coverage will be modified accordingly.

You do not have to show that you are in good health to choose Continuation Coverage. However, under COBRA, you will have to pay the cost for your Continuation Coverage, plus a two percent (2%) administrative fee.

## Trade Adjustment Assistance Act of 2002

Under the Trade Adjustment Assistance Act of 2002, certain individuals who have become unemployed as a result of imports or jobs shifted to foreign countries may be eligible for federal assistance, including a federal subsidy for COBRA coverage. In 2011, the Trade Adjustment Assistance Extension Act was passed which changed the group eligibility requirements, and individual benefits and services available under the Trade Adjustment Assistance program. Eligible Individuals must obtain a certification of Trade Act eligibility from the Department of Labor ("DOL") in order to receive Trade Act assistance and subsidies. Individuals eligible for Trade Act assistance may also have different election periods and effective dates for COBRA coverage. For more information, please call the DOL's Office of Trade Adjustment Assistance toll-free 1-888-365-6822. More information about the Trade Act is also available at www.doleta.gov/tradeact. This program is offered by the federal government and the Fund Office has no role in its administration.

## HIPAA PRIVACY

The Fund is required to take reasonable steps to ensure the privacy of your personally identifiable health information in accordance with the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and the related regulations ("federal health privacy law"). In addition, the Fund must inform you about:

1. the Fund's uses and disclosures (including breaches, as described on page 49) of Protected Health Information ("PHI");

2. the Fund's duties with respect to your PHI;

3. your rights with respect to your PHI;

4. your right to file a complaint with the Fund and the Secretary of the U.S. Department of Health and Human Services;

5. the identity of the person to contact for additional information about the Fund's privacy practices.

PHI includes all individually identifiable health information that is transmitted or maintained by the Fund, or on behalf of the Fund, in connection with the Fund's provision of medical, dental, vision and pharmacy benefits, regardless of whether the information is transmitted or maintained orally, on paper or through electronic medium (such as e-mail).

### Uses and Disclosures of PHI Made Without Your Consent

The Fund uses PHI to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Fund may disclose your PHI to insurers, third party administrators, and health care providers for treatment, payment or other health care operations purposes. The Fund may also disclose your PHI to other third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases, your authorization is not needed. The details of the Fund's uses and disclosures of your health information are described below.

### Uses and Disclosures to the Plan Sponsor

The Fund may disclose your PHI to the Trustees of the Building Trades Welfare Benefit Fund as the Plan sponsor, to enable the Trustees to administer the Plan. Such disclosures may be made without your authorization. The Trustees have certified that they will protect any PHI they receive in accordance with federal law.

## Uses and Disclosures to Business Associates

The Fund shares PHI with its "business associates," which are third parties that assist the Fund in its operations such as preferred provider networks and prescription benefit program managers. The Fund enters into agreements with its business associates so that the privacy of your health information will be protected by them. A business associate must have any agent or subcontractor to whom the business associate provides your PHI agree to the same restrictions and conditions that apply to the business associate. The Fund is permitted to disclose PHI to its business associates for treatment, payment and health care operations without your authorization as described below.

## Uses and Disclosures for Treatment, Payment, and Health Care Operations

The Fund and its business associates will use and disclose PHI without your authorization for treatment, payment and health care operations as described below.

**For Treatment.** While the Fund does not anticipate making disclosures of PHI related to your health care treatment, if necessary, such disclosures may be made without your authorization. For example, the Fund may disclose the name of a treating specialist to your treating Physician to assist your treating Physician in obtaining records from the specialist.

**For Payment**. The Fund may use and disclose PHI so that your claims for health care treatment, services and supplies can be paid in accordance with the Fund's plan of benefits. For example, the Fund may tell a doctor whether you are eligible for coverage or what portion of your medical bill will be paid by the Fund.

**For Health Care Operations**. The Fund may use and disclose PHI to enable it to operate efficiently and can include quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, conducting or arranging for medical review, legal services and auditing functions, business planning and general administrative activities. For example, the Fund may disclose PHI to its actuaries and accountants for benefit planning purposes.

## Other Uses and Disclosures That May Be Made Without Your Authorization

In addition to the uses and disclosures of PHI described above for treatment, payment or health care operations as described below, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization.

**Required by Law**. PHI may be used or disclosed for judicial and administrative proceedings pursuant to court or administrative order, legal process and authority; to report information related to victims of abuse, neglect, or domestic violence, or to assist law enforcement officials in their law enforcement duties.

**Health and Safety.** PHI may be disclosed to avert a serious threat to the health or safety of you or any other person. PHI also may be disclosed for public health activities, such as preventing or

controlling disease, Injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

**Government Functions.** PHI may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. PHI may also be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

**Active Members of the Military and Veterans**. PHI may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

**Workers' Compensation.** PHI may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

**Research**. Under certain circumstances, PHI may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

**Organ, Eye and Tissue Donation**. If you are an organ donor, your PHI may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

**Treatment and Health Related Benefits Information**. The Fund or its business associates may contact you to provide information about treatment alternatives or other health related benefits and services that may interest you, including, for example, alternative treatment, services or medication.

**Deceased Individuals**. The PHI of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

**Emergency Situations**. PHI may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

**Others Involved In Your Care**. Under limited circumstances, your PHI may be used or disclosed to a family member, close personal friend, or others whom the Fund has verified are directly involved in your care. For example, this may occur if you are seriously injured and unable to discuss your case with the Fund. Also, upon request, the Fund may advise a family member or close personal friend about (1) your general condition, (2) your location, such as "in the Hospital," or (3) your death. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Section.

**Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those people who have Power of Attorney for adults.

## Uses and Disclosures of PHI Pursuant to Your Authorization

Uses and disclosures of your PHI ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization at any time, provided you do so in writing. If you revoke a written authorization to use or disclose PHI, the Fund will not use or disclose your PHI, except to the extent that the Fund already relied on your authorization. Once your PHI has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your PHI may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

## Unauthorized Uses and Disclosures of PHI

Under the HITECH Act, the Fund must notify you of a "Breach" of your "Unsecured PHI." "Unsecured PHI" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Department of Health and Human Services. A "Breach" of Unsecured PHI is the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom the PHI is disclosed would not reasonably have been able to retain such information. Breach does not include:

- Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Fund if:
  - such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such Employee or individual, respectively, with the Fund; and
  - such information is not further acquired, accessed, used, or disclosed by any person
- Any inadvertent disclosure from an individual who otherwise authorized to access PHI to another similarly situated individual; and
- Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed by any person without authorization.

In the event the Plan discovers a Breach of Unsecured PHI, the Plan will notify you if your Unsecured PHI has been, or is reasonably believed by the Plan to have been, accessed, acquired, or disclosed as a result of such Breach, in accordance with the requirements of the HITECH Act and regulations thereunder. Unless otherwise specified in HITECH Act regulations, you will receive notice of a Breach of Unsecured PHI as soon as practicable and in no case later than 60 calendar days after the discovery of the Breach. This notification applies only to any Unsecured PHI accessed, maintained, retained, modified, recorded, stored, destroyed, or otherwise held, used, or disclosed by the Plan.

## Your Rights With Respect to Your PHI

You have the following rights regarding your PHI that the Fund creates, collects and maintains.

### *Right to Inspect and Copy Health Information*

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your eligibility and coverage under the Fund's plan of benefits as well as claims and billing records. To inspect or to obtain a copy of your health record, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below. The Fund may charge a reasonable fee based on the cost for copying and mailing records associated with your request. In certain limited circumstances, the Fund may deny your request to inspect and copy your health record. This denial will be provided in writing and will set forth the reasons for the denial and will describe how you may appeal the Fund's decision.

### *Right to Request That Your Health Information Be Amended*

You have the right to request that your PHI be amended if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed written request to the Fund's HIPAA Privacy Officer identified in this Section below. The Fund may deny your request if it is not made in writing, if it does not provide a basis in support of the request, or if you have asked to amend information that (1) was not created by or for the Fund, (2) is not part of the heath information maintained by or for the Fund, (3) is not part of the health record information that you are permitted to inspect and copy, or (4) is accurate and complete.

If the Fund denies your request, it will explain the basis for the denial in writing. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of PHI.

### *Right to an Accounting of Disclosures*

You have the right to receive a written accounting of disclosures by the Fund of your PHI made during the six years prior to the date of your request. However, such accounting will not include disclosures made (1) for treatment, payment or health care operations, (2) to you or authorized by you, (3) prior to February 17, 2010, (4) that were otherwise permissible under law and the Fund's privacy practices, or (5) that constitute incidental disclosures. To request an accounting of disclosures, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable fee based on the cost for each subsequent accounting. The Fund will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

### *Right to Request Restrictions*

You have the right to request that the Fund restrict the use and disclosure of your PHI. However, the Fund is not required to agree to your request for such restrictions, and the Fund may terminate a prior agreement to the restrictions you requested. To request restrictions on the use and disclosure of your PHI, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below.

Your request must explain what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates any agreement with respect to any restriction.

### *Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location*

You have the right to request that your PHI be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your PHI at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

### *Right to Complain*

You have the right to complain to the Fund and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Fund, submit a written complaint to the Fund's HIPAA Privacy Officer identified in this Section below.

The Fund will not retaliate or discriminate against you and no services, payment, or privileges will be withheld from you because you file a complaint with the Fund or with the Department of Health and Human Services.

### *Right to a Paper Copy of this Notice*

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below.

## Contact Information

If you have any questions or concerns about the Fund's privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund's privacy practices or if you wish to exercise one of the rights described above with respect to your PHI, please contact:

HIPAA Privacy Officer
Building Trades Welfare Benefit Fund
50 Charles Lindbergh Blvd., Suite 207
Uniondale, New York 11553
Tel: (516) 833-9300

## Changes in the Fund's Privacy Policies

The Fund reserves the right to change its privacy practices and make the new practices effective for all PHI that it maintains, including PHI that it created or received prior to the effective date of the change and PHI it may receive in the future. If the Fund materially changes any of its privacy practices, it will amend this Section and provide you with a copy of the amendment, by U.S. mail, within sixty days of the revision. In addition, copies of the amendment will be made available to you upon your written request.

## COORDINATION OF BENEFITS

It is the intent of this Plan not to duplicate payments that you may be entitled to under other Health Plans. This means, the amount paid under any other Health Plan or provider, plus whatever benefit is provided from this Plan, will not exceed one hundred percent (100%) of your incurred Customary Charge. However, in no event will this Plan pay more than what would have been payable if there were not other Health Plans or providers involved.

All benefits provided under this Plan (excluding death and dismemberment benefits) are subject to the terms of all provisions of coordination of benefits. See page 56 for the rules regarding Coordination of Benefits with other health plans.

### Right to Receive and Release Necessary Information

For the purpose of determining the applicability and implementation of the terms of this provision of this Plan or any provision of similar purpose of any other Health Plan, this Plan may (without the consent of or notice to any person) release to or obtain from any insurance company or other organization or person any information with respect to any person that the Fund considers to be necessary for those purposes. Any person claiming benefits under this Plan must furnish to the Fund any information that may be necessary to implement this provision.

### Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Health Plan, the Fund will have the right, exercisable alone and in its sole discretion, to pay over to any organization making the other payments any amounts that it may determine to be warranted, in order to satisfy the intent of this provision. Amounts so paid will be considered to be benefits paid under this Plan and to the extent of those payments the Fund will be fully discharged from liability under this Plan.

### Right of Recovery

If the Fund pays benefits in error, such as when the Fund erroneously pays a claim that is not covered under the Plan, or if the Fund advances benefits that you or your Dependent are required to reimburse because, for example, you have received a third-party recovery (see the "Subrogation and Reimbursement" Section of this SPD), you are required to reimburse the Fund in full and the Fund shall be entitled to recover any such benefits.

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

Dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your Dependent to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund provide the benefits available under the Plan and you comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your Dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by any and all methods, which includes, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments under the Plan. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you, or on your behalf and any of your Dependents. If the overpayment or advancement was made to or on behalf of your Dependent, the Fund may offset the future benefits payable by the Fund to you and any of your Dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid or on whose behalf they were paid. If the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the Fund, you or your Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed to the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit to enforce the provisions of this Plan in any state or federal court that has jurisdiction over the Fund's claim.

## Fraud

The Board reserves the right to cancel or rescind Fund coverage for any Participant or Dependent who engages in fraud or intentional misrepresentation. Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in Dependent status or accepting benefits in excess of what is covered under the Plan, will be considered fraud. In any case of fraud or intentional misrepresentation, the Fund will seek reimbursement for of retroactive benefits and may elect to pursue the matter by pressing criminal charges, to the extent permitted by law.

## COORDINATION OF BENEFITS WITH MEDICARE

### Active Participants Age 65 and Over and Their Dependents

If you work for a Contributing Employer with fewer than twenty (20) Employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, and the Fund has obtained an exception from Centers for Medicare and Medicaid Services for your Employer, then Medicare shall be primary for you and your Dependents.

If you work for an employer with more than twenty (20) Employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, the following rules apply:

1. This Plan will be primary for any person age sixty-five (65) and older who is a Participant and for any spouse, age sixty-five (65) and older of a Participant of any age.

2. You or your Dependent may decline coverage under this Plan and elect Medicare as primary. In this instance, this Plan will not pay benefits secondary to Medicare for Medicare covered services. However, you will continue to be covered by this Plan as primary until you notify the Fund in writing that you wish to elect Medicare as primary, or unless your coverage under this Plan ceases.

### Disabled Employees or Disabled Dependents Under 65

This Plan is primary for Participants or their Dependents who are under age sixty-five (65), and who are entitled to Medicare benefits due to Total Disability and who are covered under the Plan (other than End Stage Renal Disease).

### End Stage Renal Disease

This Plan will remain primary for End Stage Renal Disease for the thirty (30) months of your entitlement to Medicare due to End Stage Renal Disease, to the extent required by law. Please consult the Fund for a more detailed explanation if this may apply to you.

## SUBROGATION AND REIMBURSEMENT

Were you or your eligible Dependent injured in a car accident or other accident for which someone else may be responsible? If so, that person (or his/her insurance) may be liable for paying your (or your eligible Dependent's) medical expenses. These expenses are not covered under the Plan.

Waiting for a third party to pay for these injuries may be difficult. Since recovery from a third party can take a long time (you may have to go to court) and your creditors may not wait patiently, as a service to you, the Fund will advance your (or your Dependent's) benefits based on the requirement that you reimburse the Fund in full from any recovery you or your eligible Dependent(s) receive, no matter how such recovery is characterized. This means that you must reimburse the Fund in full if you obtain any recovery from any source, person or entity. This reimbursement and subrogation program is a service to you and your Dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays the costs incurred as a result of your or your Dependent's injuries.

You and/or your Dependent are required to notify the Fund within ten (10) days of any accident or Injury for which someone else may be liable. Further, the Fund must be notified within ten (10) days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.

If you or your Dependent receive any benefit payments from the Fund for any Injury or Sickness, and you or your Dependent recover any amount from any third party or parties in connection with that Injury or Sickness, you or your Dependent must reimburse the Fund from that recovery, the total amount of all benefit payments the Fund made or will make in the future on your or your Dependent's behalf in connection with such Injury or Sickness.

Also, if you or your Dependent receive any benefit payments from the Fund for any Injury or Sickness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or which is asserted in connection with such Injury or Sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Sickness in your or your Dependent's name and also has a right to intervene in any action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Sickness, and regardless of whether you and/or your Dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the Injury and Sickness, whether such recovery is full or partial and no matter

how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. This includes amounts payable under your or your Dependent's own uninsured motorist insurance, under insured motorist insurance, or any medical pay or no fault benefits payable. The "make-whole" doctrine does not apply to the Fund's rights of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your Dependent in obtaining recovery.

The Fund has a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your Dependent for the benefit of the Fund until paid to the Fund. You and your Dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this section, if you or your Dependent submit claims for or receive any benefit payments from the Fund for an Injury or Sickness that may give rise to any claim against any third party, you and/or your Dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement also must be executed by your or your Dependent's attorney, if applicable. However, even if you or your Dependent or a representative of you or your Dependent (including your or your Dependent's attorney) do not execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your Dependent, you or your Dependent's acceptance of such benefits shall constitute your or your Dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your Dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your Dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your Dependent recovers from a third party.

Any refusal by you or your Dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the Fund on your or your Dependent's behalf relating to the applicable Injury or Sickness, will be considered a breach of the agreement between the Fund and you that the Fund provide the benefits available under the Plan and you comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to, a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your Dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your Dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your Dependent or your attorney may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, are excluded from Plan coverage, as provided in this Section.

Under this provision, you and/or your Dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your Dependent's receipt of any recovery. If you are asked to do so, you must contact the Fund Office immediately. You or your Dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent chooses not to pursue the liability of a third party, you or your Dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your eligible Dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your Dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your Dependent waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party, including your attorney, to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the Fund, you or your Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent shall also be required to pay interest at the rate

determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

## CLAIMS REVIEW AND APPEAL PROCEDURE

The following claims and appeals information applies to all of your uninsured medical, hospital and prescription drug benefits. For your insured benefits, Life and AD&D, please refer to the booklets issued by the insurer for details on the applicable claims and appeals procedures.

## HOW DO I FILE A CLAIM FOR BENEFITS?

If you receive services from an in-network provider, your provider will automatically file a claim with the Fund on your behalf. You are not required to complete any claim forms. If you receive services from an out-of-network provider, you must ask your provider if they will file the claim. If your provide does not file a claim on your behalf, it is your responsible to file a claim directly with the Fund Office.

## WHERE DO I SUBMIT MY CLAIM FORM?

Where you file your claims will depend on the type of claim, as described below.

For all Pre-service medical claims, you should call The American Health Holding at 1-866-457-9882.

## WHAT ARE THE TIME LIMITS FOR COMPLETING AND FILING MY CLAIM FORMS?

Claims must be filed within one year after the claim has been incurred. Claims submitted after one year will be denied as untimely unless it is determined that there is a satisfactory explanation for the delay.

## HOW LONG WILL IT TAKE FOR A CLAIM TO BE DECIDED?

The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

### *Pre-service Claim*

A Pre-service claim is one that requires pre-approval under the terms of the Plan. The requirements for pre-authorization or pre-approval are described on page 2 of your SPD. Your Pre-service claims will be decided within 15 days of receipt by the Fund. If it is determined that an extension of this time is necessary, the claim will be decided within 30 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You

will be notified of the need for an extension within 15 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If your claim is filed improperly, you will be notified of the problem within five days of filing the claim. If you do not provide the information requested, or do not properly re-file the claim, the Fund will have to decide the claim based on the information it has, and your claim may be denied.

***Post-service Claim***

A Post-service claim is any other type of claim under the Plan, such as a payment for covered services after a doctor visit. You will be notified if your claim is denied within 30 days after receipt of the claim. If it is determined that an extension of this time is necessary to decide the claim, the claim will be decided within 45 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 30 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If you do not provide the information requested, the Fund will have to decide the claim on the information it has, and your claim may be denied.

***Concurrent Care Claim***

A Concurrent Care claim is a claim that the Fund is asked to approve, or has already approved for an ongoing course of treatment or a certain number of treatments over time. If the Fund determines that treatment is no longer necessary, you will be notified of the denial within a sufficient amount of time to allow an appeal before the Fund ceases or reduces coverage for your treatment. If you ask that Concurrent Care treatment be extended beyond the initially determined time, your claim will be decided no later than 24 hours after your claim is received by the Fund (if you make the claim at least 24 hours before the period or number of treatments expires).

## HOW IS A DECISION REGARDING MY CLAIM MADE?

When making decisions regarding claims, the Fund will apply the terms of the Plan and any applicable guidelines, rules and schedules, adopted by the Board of Trustees. Additionally, the Fund will take into account all information you submit in making decisions on claims and on appeal.

The Fund, at its own expense, has the right to have a Physician examine you or your Dependent as often as is reasonably required while a claim is pending. The Fund also has and the right to have an autopsy performed at its own expense, where not prohibited by law.

If the Fund has all of the information needed to process the claim, it will be processed. If your claim was a Pre-service claim, you will receive notice regarding payment of your claim.

## WHO WILL RECEIVE THE CLAIM PAYMENT?

If the Fund has all of the information needed to process the claim, it will be paid to the extent consistent with the Plan and you will receive a notice on an Explanation of Benefits form.

If you wish to have payment of a claim made directly to a service provider, you must authorize this on the claim form and the bill must indicate that payment has not been made.

Otherwise, payment of a claim is made directly to you, unless it is for a death benefit. If you die before all claims have been paid, if you fail to provide a forwarding address, or if you are determined to be incompetent, the Fund will make payment to your named beneficiary or to your estate if you do not have a named beneficiary. If a beneficiary is a minor, or is otherwise incapable of giving a valid release for any payment due him, the Plan Administrator, until a claim is timely made by the duly appointed guardian, committee, or other legally authorized representative of such beneficiary, may make payments of the proceeds otherwise payable to such beneficiary to any spouse or relative of the beneficiary, or to any other person or institution appearing to the Plan Administrator to have assumed custody and principal support of that beneficiary.

## WHAT NOTICE WILL I RECEIVE IF MY CLAIM IS DENIED?

You will be provided with a written notice of any denial of a claim (whether denied in whole or in part), which will include the following information:

- The claim involved (including the date of service, the provider involved, if applicable, and the claim amount)
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning
- the specific reason(s) for the denial
- a reference to the specific Plan provision(s) on which the denial is based
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request
- if the denial of your claim was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request
- a description of any additional material or information necessary to support 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 external review process and applicable time limits

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and any related statute of limitations or forum selection requirements

- for Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims (keep in mind that for Urgent Care Claims, you may first be notified over the phone or in person, with written notification to follow).

As part of the Fund's internal claims and appeals review process, you have the right to review your claim file and to present evidence and testimony in support of your claim and appeal. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the Fund, the Board of Trustees, or the Fund's other applicable claims-processing entities.

## WHAT STEPS MUST I TAKE TO APPEAL A DECISION TO DENY BENEFITS?

### *Pre-Service Claims*

Before you appeal to the Board of Trustees, you may wish to contact American Health Holdings with any questions or concerns you have regarding your Pre-Service medical claim denial. If you choose to do so, please contact American Health Holdings directly at 1-866-457-9882 for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to American Health Holdings, you have the right to appeal a benefit denial to the Board of Trustees within one hundred eighty (180) days of the denial of your benefit, as described above. However, if you choose to address your concerns to American Health Holdings, you must do so before you appeal to the Board of Trustees and, if you are not satisfied with the results through the provider and wish to file an appeal to the Board of Trustees, you must appeal to the Board of Trustees within one hundred eighty (180) days of the denial of your benefit. If you have addressed your concern to American Health Holdings, but have not obtained a response before the end of one hundred eighty (180) days from the denial of your benefit, you must file an appeal with the Board of Trustees before the end of that one hundred eighty (180) day period to preserve your right to appeal. If you file an appeal before you receive a response from American Health Holdings, you may ask the Board of Trustees to defer a decision on your appeal until you receive a response from American Health Holdings; after you receive a response from American Health Holdings, you must then notify the Trustees as soon as possible whether you wish to proceed with the appeal.

### *Other Claims*

If your benefits are denied, in whole or in part, and you wish to appeal the Fund's decision, you (or your representative) should request that the Board of Trustees review your benefit denial by submitting a written appeal to the Trustees. The Trustees will review your appeal.

Your written appeal should state the reason for your appeal. You may submit written comments, documents, records, and other information relating to the claim. If you choose to appeal, upon

request you can receive, free of charge, access to and copies of all documents, records and other information relevant to your claim.

Your appeal should be sent to:

Board of Trustees
Building Trades Welfare Benefit Fund
c/o Dickinson Group, LLC.
50 Charles Lindbergh Boulevard, Suite 207
Uniondale, New York 11553

## WHEN MUST I SUBMIT MY APPEAL?

You have 180 days from the day you received notice of the initial decision to appeal your claims.

## WHEN WILL A DECISION REGARDING MY APPEAL BE MADE?

Once your appeal is received by the Trustees, the time to issue a decision will depend on the type of claim.

***Pre-service Claims***

Appeals of Pre-service claims will be decided within 30 days after the Trustees receive the appeal.

***Post-service Claims***

If the Board of Trustees is holding regularly scheduled meetings at least quarterly, appeals of Post-service claims will be decided at the next quarterly meeting of the Trustees (or a designated committee of Trustees) immediately following the receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Trustees will send you a notice of this decision within 5 days of the decision.

If the Board of Trustees is holding regularly scheduled meetings less often than quarterly or otherwise in the discretion of the Board, appeals of post-service claims will be decided within a reasonable time but in no event will you be notified of the determination later than 60 days after receipt of the appeal.

*Concurrent Care Claims*

Appeals of Concurrent Care claims are governed by the provisions above for Pre-service or Post-service claims, whichever applies to the particular claim.

*Urgent Care Claims*

In the case of an appeal of an Urgent Care Claim, the reviewer will notify you of the decision on your appeal within 72 hours after receipt of your appeal.

## WHAT HAPPENS IF MY CLAIM IS DENIED ON APPEAL?

If your claim is denied on appeal, you will receive a written explanation that describes:

- The claim involved (including the date of service, the provider, if applicable, and the claim amount);
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered a request for external review);
- The specific reason or reasons for denial, including the standards used and a discussion of the decision;
- Reference to specific Plan provisions on which the denial is based;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- If the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement of your right to seek external review and to bring a civil action under Section 502(a) of ERISA following a denial of your appeal, including any applicable statute of limitations and forum selection requirements.

If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination or a subordinate of such person. In reviewing a denied medical claim, the Trustees will not automatically presume that the initial decision was correct. Rather, the medical claim will be reviewed with no reliance on the record used in making the

initial benefit determination, and, by a named fiduciary of the plan who did not make the determination you are appealing and who is not a subordinate of any individual who made the determination that you now appeal.

If you wish to file lawsuit regarding the denial of a claim of benefits, you must do so within three (3) years of the date the Trustees denied your appeal. For all other actions against the Fund or Trustees, you must file a lawsuit within three (3) years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, any lawsuit against the Fund or the Trustees must be filed in either the Eastern District or Southern District Courts in the State of New York. These rules apply to all claimants, including you, your spouse, your Dependents, and any provider who provided services under the Plan. This Section applies to all litigation against the Fund and Trustees, including litigation in which the Fund is named as a third party defendant.

**External Review of Denied Claims**

If your claim for benefits has been denied and if you have exhausted the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an external independent review organization ("IRO"). External review is limited to claims involving medical judgment (e.g., lack of Medical Necessity, or a determination that a claim is Experimental or cosmetic) or a rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal). Requests for external review are filed with the Fund office.

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

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

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

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

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

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

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

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

*Reversal of the Fund's decision*. If the IRO issues a final decision that reverses the Fund's decision, the Fund will pay the claim.

## Expedited External Review of Denied Claims

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The Fund will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision on as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

## OTHER IMPORTANT INFORMATION

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan.

The decision of the Board of Trustees is final and binding. However, you have the right to file a suit in federal or state court under the Employee Retirement Income Security Act on your claim for benefits, provided that you had filed an appeal pursuant to the Fund's appeal procedures described above and your appeal has been denied.

*New York Surcharge*

New York State law has many rules regarding how health care is financed in New York State. One of these rules is that there is a surcharge (an additional amount added to the usual charge) to Expenses for services provided by any of the following facilities located in New York State: Hospitals, both in-patient and out-patient (including emergency room), diagnostic and treatment centers, and ambulatory surgical centers. This surcharge changes from year to year. It is the responsibility of the Plan to pay the surcharge on any portion of the charges that are paid for by the Plan. This surcharge will be considered a paid claim. The surcharge will be considered a paid claim for subrogation and overpayment purposes under the Plan as well. It is the Participant's and/or the Dependent(s)'s responsibility to pay the surcharge to the provider on any amounts that are not paid for by the Plan.

In addition to the Expense surcharge, there is a monthly surcharge that the Plan must pay directly to the State of New York for each Participant and/or Dependent(s) residing there. This surcharge varies based on individual or family coverage and the geographic region in which the Participant and/or Dependent(s) live.

## ERISA RIGHTS AND INFORMATION

As a Participant in the Building Trades Welfare Benefit Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participant shall be entitled to:

### Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the Fund's office and at other specified locations, such as worksites and union halls all documents governing the Plan including insurance contracts, 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 Employee Benefits Security Administration.

(b) Obtain copies of all Plan documents and 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, and other Plan information upon written request to the Fund. The Fund may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each Participant with a copy of this summary financial report.

## Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group Health Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 Dependents.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require the Fund to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof

concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. 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 this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Fund, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

## GENERAL PLAN INFORMATION

### Eligibility and Benefits

The Plan's requirements pertaining to eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits are set forth in the preceding pages of this booklet.

### Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss forfeiture or suspension of any benefits are contained in the preceding pages of this booklet. Please also refer to the booklets for your Life and AD&D benefits for additional information regarding circumstances which may affect your benefits.

### Sources of Plan Contributions

Welfare Plan contributions are made to a qualified tax-exempt Trust Fund. Sources of contributions to the Fund are contributions made by participating employers pursuant to collective bargaining agreements or other written agreements, except that retiree benefits are provided on a self-pay basis. The method of calculating contributions is outlined in the applicable collective bargaining agreements and participation agreements. These monies are reserved irrevocably for payments on behalf of Plan Participants and for administrative Expenses. The funds cannot be used for any other purpose and cannot be withdrawn by either the Contributing Employers or the Union. The financial activities of the Trust Fund are audited annually by a Certified Public Accountant.

In no event shall any assets of the Fund revert to any Employer. In the event of termination of the Plan, the allocation and disposition of plan assets will be in accordance with the Board of Trustees' determination.

### Medium for Providing Benefits

This Plan was established and is maintained in accordance with collective bargaining agreements or participation agreements with Contributing Employers. Upon written request to the Fund Office, Participants and Dependents may obtain copies of the collective bargaining agreements, and copies are also available for examination by Participants and Dependents at the Fund Office.

Your medical, and, prescription drug benefits are provided directly through the Fund. The Fund has entered into contracts with the Hartford Life Insurance Company for your Life Insurance benefits. This benefit is fully insured and paid pursuant to an insurance contract and the insurance company provides claims processing services for these benefits. The address for the Hartford Life Insurance Company is listed below:

Hartford Life Insurance Company
200 Hopmeadow Street
Simsbury, CT 06089

## IMPORTANT SUMMARY PLAN INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

### Name of Plan

The name of the Plan is the "Building Trades Welfare Benefit Fund".

### Plan Sponsor

The name and address of the Plan Sponsor is:

The Building Industry Electrical Contractors Association, Inc.
926 Lincoln Avenue, Suite B
Holbrook, NY 11741

### Trustees

The names and addresses of the Trustees of the Plan are:

Frank Rappo
President
R&L Systems, Inc.
37-20 56th Street
Woodside, NY 113377

Eric Olynik
c/o Building Trades Welfare Benefit Fund
50 Charles Lindbergh Boulevard, Suite 207
Uniondale, New York 11553

**Counsel**
Slevin & Hart, P.C.
1625 Massachusetts Avenue, N.W., Suite 450
Washington, D.C. 20036

**Administrative Manager**
Dickinson Group, LLC
50 Charles Lindbergh Boulevard, Suite 207
Uniondale, New York 11553

**Auditor**
Steinberg, Steckler & Picciurro
462 Seventh Avenue,16th Floor
New York, NY 10018

**Employer Identification Number and Plan Number**

The Employee Identification Number (EIN) assigned to the Plan Sponsor by the Internal Revenue Service is 26-1140509. The Plan Number the Board of Trustees has assigned to the Plan is 501.

**Type of Plan**

The Plan is a group health plan under the Employee Retirement Income Security Act of 1974 (ERISA). It provides life insurance, hospital, surgery, medical, laboratory and x-ray, home health care, and prescription drug benefits described in this Summary Plan Description.

**Type of Administration**

The Plan is administered by the Board of Trustees of the Building Trades Welfare Benefit Fund.

**Agent for Service of Legal Process**

The Agent for service of legal process is:

The Trustees of the Building Trades Welfare Benefit Fund
50 Charles Lindbergh Boulevard, Suite 207
Uniondale, New York 11553

Service of legal process also may be made on a Plan Trustee.

**The Plan Year**

For purposes of maintaining the Plan's records, the Plan year begins January 1 and ends December 31 of each year.

**The Plan Website**

http://www.buildingtradeswelfund.org/index.html

**Benefits and Rules Changes**

It is intended that this Plan will be maintained indefinitely. However, the Trustees may at any time modify or reduce any benefit coverage or change any rule or regulation, in order to protect the financial soundness of the Plan or to better serve the Participants. Any changes made will be uniformly applied to all Participants.
The Trustees shall have the sole power and discretion to construe the provisions of the Plan and the terms used herein. Any construction adopted by the Trustees in good faith shall be binding on the Union, the Contributing Employers and all Plan Participants.