NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

NYC District Council of Carpenters Welfare Fund

summary plan description

TABLE OF CONTENTS

ABOUT THIS BOOKLET

This handbook summarizes the benefits provided by your Welfare Fund (the "Fund") as of April 1, 2003, and it replaces all earlier descriptions you may have received. It is intended to provide an easy-to-understand explanation of your benefits. It does not include all provisions in the official governing documents and insurance contracts, especially those relating to situations that don't occur often or that affect only a few participants. In the event of any conflict between this summary and the official plan documents, the official plan documents always govern.

From time to time there may be changes in the benefits and/or procedures under one or more of the plans that make up the Fund. In such a case, either the administrator of the affected plan or the Fund Office will notify you in writing of any change. Announcements will be sent directly to you at the address that appears in Fund Office records. For this reason, it is important to remember to notify the Fund Office if your address changes. You should also keep announcements of changes with this booklet.

Ayuda en Español
Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el New York City District Council of Carpenters Welfare Fund. Si usted tiene dificultad en entender cualquier parte de este folleto, puede comunicarse con la oficina del plan en 395 Hudson Street, New York, NY 10014. Las horas de oficina son de 8:30 a.m. a 5:00 p.m., lunes a viernes. También puede llamar a la oficina del plan al 800-529-3863 para ayuda.

AN OVERVIEW OF YOUR WELFARE BENEFITS

The New York City District Council of Carpenters Welfare Fund (the "Fund") provides a comprehensive package of benefits that includes:

- health care coverage with medical (hospitals, doctors and other necessary medical services), prescription drug, dental, vision and hearing benefits;
- disability benefits that help protect you in the event that illness or Injury prevents you from working;
- life insurance benefits that help protect your family in the event you die; and
- a scholarship program that can provide financial assistance for your child's education.

This handbook offers a comprehensive resource you can use when you or your family members need information about any of your benefits. It's been organized in a way that we hope will give you quick access to easy-to-understand explanations of your benefits.

To make the best use of your benefits, you are urged to review these materials carefully and share them with your family. We hope this information will answer all of your questions. However, if you need more information, please contact:

About your…	Call…
Medical coverage (Active Employees and Retirees not eligible for Medicare)	Empire BlueCross BlueShield 800-553-9603
Medicare Supplemental	C&R Consulting 866-320-3807
Dental coverage	Self-Insured Dental Services 877-592-1683 516-396-5500 718-204-7172
Prescription drug program	Caremark 800-378-0972 800-831-4440
Vision and hearing aid participating providers	Comprehensive Professional Systems Inc. 212-675-5745 General Vision Services 212-594-2580 Vision Screening (vision only) 800-652-0063
Life Insurance and Disability benefits	The Fund Office 212-366-7300 800-529-3863
Scholarship Program	The Fund Office 212-366-7300 800-529-3863
Plan Administration and all other questions	The Fund Office 212-366-7300 800-529-3863

Participants may also seek assistance or information from the U.S. Department of Labor regarding their rights under the federal laws known as “ERISA” and “HIPAA.”

ABOUT YOUR PARTICIPATION

This section describes the eligibility rules for medical, prescription drug, dental, life insurance, vision care and hearing aid coverage that apply to eligible Active Employees, Retirees and covered dependents. The different rules that apply for disability and scholarship benefits are explained in the sections on those benefits.

Eligibility for Active Employees

You are eligible to participate in this Plan as an Active Employee after you have worked 250 hours in Covered Employment. These 250 hours "buy" you three months, or a calendar quarter, of coverage. If you work at least 250 hours in Covered Employment during one of the following periods, you will be covered for the calendar quarter beginning on the date shown below.

If you work 250 hours during	Coverage Begins
October, November, December	January 1
January, February, March	April 1
April, May, June	July 1
July, August, September	October 1

Any hours in excess of 250 may be added to your "bank" for use in a later quarter. Likewise, if you work less than 250 hours, those hours may be saved in the bank for future use. You may not accumulate more than 750 hours in the bank at any time.

> **Example:** Assume you have no hours in your bank but work 350 hours in April, May and June. 250 of those hours will be used to "buy" coverage for the calendar quarter beginning July 1.
>
> The additional 100 hours will remain in your bank and may be used towards coverage for a later calendar quarter. If you work at least 150 additional hours between July and September, you will have enough hours in your bank to qualify for coverage in the quarter beginning October 1.

Words that are capitalized in this summary—such as "Active Employee," "Retiree," and "Injury"—are generally defined in the section called "Glossary" at the end of the SPD. In some cases, they are also defined in the text.

Forfeiture of Hours in the Bank

Your bank hours will be forfeited if:

- Hours in the bank have not been used for a consecutive nine-month period. (However, the Fund will maintain separate "buckets" for hours to ensure that they are forfeited on a rolling basis.)
- You have knowledge and do not notify the Fund Office that hours you have worked have not been reported or have been only partially reported.
- You fail to notify the Fund of any additional group health coverage for your dependents.

Note: It's a good idea to keep your pay stubs and compare them to the statements you receive confirming the number of hours your employer has reported to the Benefit Funds on your behalf. You are required to submit a Benefit Hours Shortage report as soon as you become aware that your employer is not reporting your hours or is reporting your hours incorrectly.

Continued Eligibility During Periods of Disability

There are two provisions that help keep your coverage in force in the event of disability—"eligibility credit" and "disability waiver." It is important to note that both provisions require that you be an eligible Active Employee at the time that you become disabled.

Eligibility Credit. If you receive short-term disability or Workers' Compensation benefits under applicable state law, and you are an eligible Active Employee, the Fund will credit you with 20 hours for each week you receive those benefits, up to a total of 26 weeks, or 520 hours. To receive this credit, you must submit proof that you are in receipt of these benefits to the Fund Office.

Continuation of Coverage during Total Disability ("Disability Waiver"). If you become "Totally Disabled," and you are an eligible Active Employee, your Fund coverage will remain in effect for as long as you remain disabled. This benefit is often referred to as a "disability waiver." It does not provide a cash benefit.

You are considered "Totally Disabled" during the first 24 months of a disability if you are unable to work in Covered Employment due to an illness or Injury. After 24 months, you are Totally Disabled if you are unable to work in any occupation.

To apply for a disability waiver, you may call the Fund Office to obtain an application. In connection with your application, the Fund reserves the right to require that you undergo (at the Fund's expense) an independent medical examination to help determine the extent of your disability. The Fund Office and, on appeal, the Trustees determine the extent of your disability based on the documentation submitted. This decision is final and binding on all concerned. If you are determined to be Totally Disabled, the Fund Office may request proof of continued disability from time to time.

If you receive a Social Security disability award, and you were an eligible Active Employee on the date of disability established by the Social Security Administration, you automatically qualify for continued coverage under the Fund as long as you remain Totally Disabled for Social Security purposes. You will be required to submit proof of Social Security eligibility from time to time.

If you become Totally Disabled and are unable to work in Covered Employment, you should contact the Fund Office for information on any benefits to which you may be entitled under your pension plan.

When total disability ends. In the event your disability waiver ends because you are no longer Totally Disabled under the Fund definition, your Fund coverage will remain in force for three months from the last day of the month in which your disability waiver ends. If you return to Covered Employment during this period, you will continue to be covered for up to six consecutive months from the last day of the three-month extension period provided that you work at least 40 hours in Covered Employment during each preceding month.

Eligibility for Retirees

When you retire, any remaining hours in your bank are used to continue your coverage as an Active Employee. In order for coverage to continue after your bank hours are used, you must qualify for Retiree health coverage.

You do not "bank" hours if you work in Covered Employment while you are retired. Therefore, you will not re-qualify for coverage as an Active Employee once you are eligible as a Retiree, even if you work 250 hours in Covered Employment.

In order to be eligible for Health and Welfare coverage as a Retiree, your employer or employers must have contributed to the Fund for you as an Active Employee, and you must satisfy one of the three requirements below:

- You have earned at least 30 Vesting Credits with the New York City District Council of Carpenters Pension Fund (the "Pension Fund"). In general, you earn one Vesting Credit for each calendar year in which you work 870 hours or more in Covered Employment;
- You have earned at least 15 Vesting Credits under the Pension Fund and, during the 60-month period immediately preceding the effective date of your pension, you are eligible as an Active Employee for at least 24 months; or
- You have no break in service between the year in which you reach age 55 and the year in which you earn your 15th Vesting Credit. For purposes of Retiree health coverage only, a break-in-service is defined as any calendar year in which you do not work at least 300 hours in Covered Employment.

Return to work. If you return to Covered Employment and your pension is suspended, your Retiree health coverage will continue for up to six months as long as you work at least 40 hours in each month. (Note that a special rule for disability pensions is discussed in the following section.)

Disability Pensioners

A Disability Pensioner who is an eligible Active Employee when disability commences will continue to be covered as described in the preceding section, "Continued Eligibility During Periods of Disability." (Please refer to the subsection called "Continuation of Coverage during Total Disability.")

If you are not eligible as an Active Employee when disability commences and you have earned less than 15 Vesting Credits, you will qualify for Retiree health coverage as a Disability Pensioner if, during the 60-month period immediately preceding the effective date of pension, you are eligible as an Active Employee for at least 24 months.

If you are not eligible as an Active Employee when disability commences but you have earned at least 15 Vesting Credits, you will be eligible for Retiree health coverage as a Disability Pensioner provided that you satisfy one of the three rules in the preceding "Eligibility for Retirees" section.

Disability Pensioners who are eligible and in receipt of a Social Security Disability Award should review the section called "Medicare" later in this summary for important information.

If your disability pension is suspended because you recover or you no longer qualify, your Retiree coverage will automatically continue for up to three months. It will continue for up to six consecutive months after the first three months if you work at least 40 hours in Covered Employment in each of those six months. During such six-month period, you will begin accumulating hours in your bank towards future eligibility.

Dependent Coverage

If you are covered, your eligible dependents may be covered for medical, dental, prescription drug, vision care, hearing aid and dependent life insurance benefits. Eligible dependents include your:

- lawful spouse;
- unmarried Children, until December 31 of the year in which they reach age 19;
- unmarried Children, until they reach age 25, if they are full-time students at an accredited educational institution;
- unmarried Disabled Children of any age, who are primarily dependent upon you for support; and
- dependent parents (if you are not married and have no eligible dependent Children, you may cover a parent(s) who lives in the United States and is claimed as a dependent on your federal income tax return for the preceding year).

Coverage for the dependent Children described above generally continues until the end of the year in which they reach the limiting age or graduate. If a dependent child marries, his or her coverage ends immediately.

Coverage for your eligible dependents starts at the same time as your coverage, provided you complete the required enrollment materials (described below), and they will receive the same medical, dental, prescription drug, vision care and hearing aid coverage that you do. Each eligible dependent also receives $1,000 of life insurance (but not AD&D insurance), which is payable to you if the dependent dies.

To cover an eligible dependent, you must provide proof of dependent status, as specified by the Fund Office.

To make sure coverage for your dependents starts at the same time as your coverage, you need to provide enrollment documents to the Fund Office. You must provide, as applicable:

- a copy of a marriage certificate if you are enrolling a spouse;
- a copy of a birth certificate or documentation of adoption if you are enrolling a child;
- a copy of your tax return from the previous year if you are enrolling a dependent parent; or
- any other materials that the Fund Office may require to verify a dependent's eligibility.

If you acquire dependents after your coverage begins, they would become covered on the date they become eligible dependents.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) is an order issued by a state court or agency that requires an employee to provide coverage under group health plans to a child. A QMCSO usually results from a divorce or legal separation. Whenever such an order is received by the Fund, its qualified status is carefully reviewed by the Fund in accordance with QMCSO procedures adopted by the Trustees and federal law. For more information on QMCSOs, or to obtain a copy of the Fund's QMCSO procedures free of charge, contact the Fund Office.

Changes in Status

After your coverage under the Fund begins, it is important that you **notify the Fund Office immediately by calling toll-free 800-529-3863** if you have either a change of address or one of the changes in status described below, including:

- marriage, divorce or annulment;
- birth, adoption of a child or placement of a child with you for adoption;
- you are not working and you are receiving Workers' Compensation benefits or disability benefits;
- a dependent child reaches a limiting age or otherwise ceases to be eligible for dependent coverage (for example, due to marriage or end of full-time studies);
- you or your dependent becomes entitled to Medicare or Medicaid;

- you take a leave of absence, including military leave and leave for family or medical purposes;
- a covered dependent dies; or
- your employment status changes (i.e., termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; or if the eligibility conditions of another employee benefit plan you or your dependents participate in change and as a result, that individual becomes or ceases to be eligible under another plan).

If you have coverage when a child is born, your newborn will automatically be covered under your medical coverage for illness or Injury for 30 days from the date of birth. To continue coverage for your child beyond that time, you need to enroll the child, so be sure to call the Fund Office at 800-529-3863.

The Fund complies with the special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Coverage Following Death

If you die while an eligible Active Employee or an eligible Retiree, your spouse will receive the coverage described above for up to 60 months from the date of your death. Your dependent Children will also receive coverage for up to 60 months, as long as they continue to meet the definition of an eligible dependent.

The coverage for your dependents when you die runs concurrently with their eligibility to continue coverage under the federal law known as "COBRA" (see the subsection called "COBRA" later in this section) and satisfies the Fund's obligation under federal COBRA law. Although COBRA coverage is not available after the period of extended coverage expires, dependents may be able to convert their group coverage to an individual health care policy. Your dependents would have to pay the full cost of the conversion plan, and the benefits might not be the same as those offered by the Fund.

If you die, your surviving dependents may be entitled to coverage for up to 60 months.

Continued Coverage During Certain Leaves of Absence

Family and Medical Leave. Under the Family and Medical Leave Act (FMLA), you may continue to be covered by the Fund while on a leave of absence for specified family or medical purposes, such as the birth or adoption of a child; to provide care for a spouse, child or parent who is ill; or for your own serious illness. If you are eligible for FMLA leave for one of the above qualifying family and medical reasons, you may receive up to 12 weeks of unpaid leave during a 12-month period. During this leave, you may be entitled to receive continued Health coverage under the Fund under the same terms and conditions as if you had continued to work. Your employer is required to continue to pay your contributions for that coverage during the period of leave. To be eligible for continued benefit coverage during your FMLA leave, your employer must notify the Fund that you have been approved for FMLA leave. Your employer, not the Fund, has the sole responsibility for determining whether you are granted leave under FMLA. If you do not return to Covered Employment after your coverage ends, you are entitled to COBRA continuation of coverage, as described later in this section. (When you do not return to covered employment at the end of your leave, you may also be required to provide reimbursement for the cost of coverage during your absence.)

Continued Coverage During Military Leave. If you are on active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days, USERRA permits you to elect COBRA continuation coverage for you and your dependents at your own expense for up to 18 months. (See later in this section for more information on COBRA.)

When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating employer, provided that you return to employment within one of the following time frames:

- 90 days of the date of discharge if the period of military service is more than 180 days;
- 14 days from the date of discharge if the period of military service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time an additional eight hours) if the period of service was less than 31 days.

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

When Coverage Ends

Your eligibility for benefits may end for any of the following reasons:

- You or your covered dependents no longer meet the Fund's eligibility requirements (see "Who's Eligible" for complete details, but typically this would occur if you had less than the required number of hours in your bank);
- The Fund or insurance company terminates the contract that provides your benefits;
- You or your covered dependents make a false statement on an enrollment form or a claim form or otherwise engage in fraud; or
- Your dependents' coverage will end on the date your coverage ends or on the date they no longer qualify as eligible dependents under the plan, whichever occurs first.

Your HIPAA Rights

When your Fund coverage ends, under the federal law known as HIPAA, you and/or your dependents are entitled by law to, and will be provided with, a Certificate of Creditable Coverage. Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to your and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- on your request, within 24 months after your Fund coverage ends;
- when you are entitled to elect COBRA;
- when your coverage terminates, even if you are not entitled to COBRA; or
- when your COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund Office.

Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the health care benefits described in this booklet.

Qualifying COBRA Events. The chart below shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue.

If You Lose Coverage Because	These People Would Be Eligible	For COBRA Coverage Up To
Your employment terminates*	You and your covered dependents	18 months**
Your working hours are reduced	You and your covered dependents	18 months**
You are on active military leave	You and your covered dependents	18 months
You die	Your covered dependents	36 months***
You divorce	Your covered ex-spouse	36 months
Your dependent Children no longer qualify as eligible dependents	Your covered dependent Children	36 months

* For any reason other than gross misconduct.

** Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become Totally Disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months' coverage will increase to 150% of the full cost of coverage.

*** If you die, your covered dependents may be eligible to continue coverage at the Fund's expense for up to 60 months, as described earlier in this section. The 36 months of COBRA continuation is included in the coverage the Fund provides to your dependents after you die.

Newborn Children. If you have a newborn child adopt a child or have a child placed with you for adoption while your continued coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child's birth, adoption or placement for adoption.

FMLA Leave. If you are on an FMLA leave of absence, you will not experience a qualifying event. However, if you do not return to active employment after your FMLA leave of absence, you will experience a qualifying event of termination of employment. The qualifying event of termination of employment will occur at the earlier of the end of the FMLA leave or the date that you give notice to your employer that you will not be returning to active employment.

Multiple Qualifying Events. If your covered dependents experience more than one qualifying event while COBRA coverage is still in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. The two periods combined may not exceed a total of 36 months from the date of your termination (the first qualifying event).

Notice of COBRA eligibility. Both you and the Fund Office have responsibilities when qualifying events occur that make you or your covered dependents eligible for continued coverage. The Fund Office will notify you when you have insufficient hours in the bank for coverage.

Your family should notify the Fund Office in the event you die. You or your eligible dependents are responsible for informing the Fund Office of a divorce, a child losing dependent status or a determination of Social Security disability within 60 days of the date of the event. If you do not notify the Fund by the end of that period, your dependents will not be entitled to continued coverage. After the Fund has been notified of a qualifying event, it will send you information about your COBRA rights. You will have 60 days to respond if you want to continue coverage. If you do not elect COBRA coverage, your coverage will end.

Paying for COBRA coverage. If you or a covered dependent chooses to continue coverage under COBRA, you or your covered dependent has to pay the full cost of continued coverage under COBRA plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, your premium may increase to 150% of the full cost of continued coverage during the 19th to 29th months of coverage. Your first payment must be made within 45 days after you elect to continue coverage. All subsequent payments will be due on the first day of each month for that month's coverage. You will be notified in advance by the Fund Office if the amount of your monthly payment changes.

The Fund has a special policy concerning your dependents' coverage after you die. Under this policy, your dependents do not have to pay for COBRA coverage. The Fund will pay the full amount.

When COBRA coverage ends. COBRA coverage for you and/or your covered dependents may end for *any* of the following reasons:

- Coverage has continued for the maximum 18-, 29- or 36-month period.
- The Fund no longer provides group health coverage.
- The Fund terminates coverage for cause, such as fraudulent claim submission, on the same basis that coverage could terminate for a similarly situated Active Employee.
- You or a dependent does not pay the cost of your COBRA coverage when it is due or within any grace period.
- You or a dependent becomes covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- The person electing coverage is widowed or divorced, subsequently remarries, and is covered under the new spouse's group health plan.
- You are continuing coverage during the 19th to 29th months of a disability and the Social Security Administration determines you are no longer disabled.
- You or a covered dependent becomes entitled to Medicare.

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

Certificate of Creditable Coverage. When your COBRA continuation coverage ends, you will be provided with a Certificate of Creditable Coverage. The certificate may help reduce or eliminate any pre-existing condition exclusion when you enroll in another health plan. The Certificate of Creditable Coverage is part of federal HIPAA legislation (described earlier in the section called "Your HIPAA Rights").

COBRA claims. Claims incurred by you will not be paid unless you have elected COBRA coverage and pay the premiums, as required by law.

Summary. This description of your COBRA rights is only a general summary of the law. The law itself must be consulted to determine how the law would apply in any particular circumstance.

Continuation Under State Law

If you are not entitled to continuation coverage under COBRA, you may be entitled to continuation of coverage under the provisions of your state insurance law.

If you have any questions about eligibility, call the Fund Office at 212-366-7300 or 800-529-3863.

HOSPITAL AND MEDICAL BENEFITS

Which Plan You Receive

Your hospital and medical coverage is described in the next section of this summary book. The Fund provides three plans with different levels of coverage. You may be eligible for one of the plans as follows:

The Active Plan provides coverage to eligible Active Employees and their dependents, and surviving dependents of deceased eligible Active Employees. An Active Employee is a participant who is currently eligible using bank hours. These benefits are provided through Empire BlueCross BlueShield.

The Retiree Plan provides coverage to eligible Retirees and their dependents under 65 years old, and not otherwise eligible for Medicare. A Retiree is any eligible participant who is not currently eligible using bank hours. These benefits are also provided through Empire BlueCross BlueShield.

The Medicare Supplemental Plan provides coverage to eligible Retirees age 65 and over, their dependents age 65 and over and a Retiree or dependent who is eligible for Medicare or becomes eligible for Medicare prior to age 65. Under this Plan, covered benefits that are subject to Medicare deductibles and coinsurance are provided through C&R Consulting, the company the Fund has retained to administer the Medicare Supplemental portion of the program.

> If you are eligible for Medicare, or become eligible for Medicare, and you are not currently eligible for Fund benefits using bank hours, Medicare has the primary responsibility for your claims; the Welfare Fund has secondary responsibility. You must enroll in both Medicare Part A and Medicare Part B as soon as you become eligible. If you are eligible for Medicare but do not enroll in both Part A and Part B, Fund benefits will be limited to secondary responsibility. The section called "Medicare" information tells you about how Medicare and the Medicare Supplemental Plan work.

How the Plan Works

The Fund's hospital and medical coverage for Active Employees and Retirees is offered through a "PPO" (preferred provider organization) administered by Empire BlueCross BlueShield ("Empire"). Your coverage under the Active Plan and the Retiree Plan includes a wide range of medical services, including:

- hospital services;
- the services you receive from doctors and other health care providers, both in and out of the hospital;
- tests and X-rays of;
- durable equipment and supplies; and
- specialized services such as hospice care, home health care, physical therapy, psychotherapy, and treatment for alcohol and substance abuse.

This section summarizes these benefits and Empire's procedures. You can reach Empire by phone at 800-553-9603 or on the Web at **www.empireblue.com**. On the website, which is accessible 24 hours a day, seven days a week, once you're registered, you can:

- locate network providers and participating hospitals;
- check claim status;
- view Explanations of Benefits ("EOBs") and issued checks;
- request copies of checks;
- request new identification cards;
- print temporary ID cards;
- get wellness information; and
- update your contact information.

Precertification

Keep in mind that precertification by Empire is *required* for a variety of plan benefits,* including admission to a hospital and other facilities, such as skilled nursing facilities and hospices, surgery, maternity care, home health care, certain diagnostic tests and procedures, and certain types of equipment and supplies.

Empire's Medical Management Program handles precertification. You can reach them at 800-553-9603. A planned hospital admission or surgery should be precertified at least two weeks ahead of time. An emergency admission should be certified no later than 48 hours after hospital admission, unless it is not possible to do so within that time. Pregnancy should be precertified within three months of the beginning of the pregnancy and again within 24 hours after delivery. If you fail to precertify when required, your benefits may be reduced or denied.

Don't forget that certain benefits need to be pre-certified by Empire. You can find out which services need precertification in the section called "Your PPO Benefits at a Glance."

* Please refer to the "Your PPO Benefits at a Glance" section for more details on which services need to be precertified.

In-Network and Out-of-Network Services Under Empire BlueCross BlueShield

In-Network services are health care services provided by a doctor, hospital or other health care facility that has been selected by Empire or another Blue Cross or Blue Shield plan to provide care for PPO members. Some of the key features of in-network services include:

- The ability to choose providers from Empire's network of doctors and hospitals in New York State, as well as the national network of Blue Cross and Blue Shield plans;
- The freedom to use an in-network specialist without a referral;
- Benefits for office visits and many other services that are paid in full after a small copayment; and
- Usually, there are no claim forms to file.

Out-of-Network services are health care services provided by a licensed provider outside of Empire's PPO network or the PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you may choose in-network or out-of-network service. However, some services are only available in-network, and these are described later. When you select out-of-network services that are covered by the plan:

- You pay an annual "deductible" and "coinsurance" on each covered service, plus any amount above the "Allowed Amount" (the maximum Empire will pay for a covered service);
- You will usually have to pay the provider when you receive care;
- You will need to file a claim form to be reimbursed by Empire; and
- Payments from Empire are subject to a lifetime maximum benefit per person.

The deductible applies separately to each family member until the family deductible is met. However, there is an exception to this policy called a "common accident benefit." If two or more family members are injured in the same accident and require medical care, only one individual deductible must be met for all care related to the accident.

The following two examples show how the plan's benefit for out-of-network expenses is calculated.

> **Example under Active Employee Plan.** Assume you go to a doctor in Empire's PPO Network. You pay $10 and the plan pays the balance — there is no other cost to you.

Suppose you instead sought out-of-network care for the same problem, and the out-of-network doctor charged you $100. Empire initially determines that the "Allowed Amount" for the service is $80. Then, assuming you have already met the yearly deductible, the plan will pay 80% of $80, or $64, and you will pay $16 as coinsurance. You will also be responsible for the $20 charged that exceeds the Allowed Amount, so the total amount you will be required to pay out of pocket for this service is $36.

Example under Retiree Plan. If you go to a doctor in Empire's PPO network, you pay a $12 copay and the plan pays the balance — there is no other cost to you.

If, as in the example above, you instead sought out-of-network care and the out-of-network doctor charged you $100, here's how your cost is calculated: If the "Allowed Amount" is $80, then, assuming you have already met the yearly deductible, the plan will pay 70% of $80, or $56, and you will pay $24 as coinsurance. You will also be responsible for the $20 charged that exceeds the Allowed Amount, so the total amount you will be required to pay out of pocket for this service is $44.

Finding a Network Provider

The Fund Office will give you a copy of Empire's PPO directory free of charge. You can also locate a provider by calling Empire or visiting its website **(www.empireblue.com)**.

Your PPO Benefits Out of Area

When traveling in or outside the United States, you can call 800-810-BLUE (2583) or visit **www.bcbs.com** for more information on participating providers.

Your PPO Benefits at a Glance

Empire's PPO provides a broad range of benefits to you and your family. Following is a brief overview, in chart format, of your coverage under the Active and Retiree plans. A separate chart summarizing the benefits under the Medicare Supplemental Plan is in the section called "Medicare."

When you see this sign on the chart, you'll know that you or your doctor will need to precertify these services with Empire's Medical Management Program. In most cases, it is your responsibility to call. In some cases, the provider or supplier of services needs to call.

HOSPITAL AND MEDICAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS NOTE: All footnotes are explained at the end of this chart.			
		YOU PAY	
		IN-NETWORK	OUT-OF-NETWORK[1]
	DEDUCTIBLE	None	$200 per individual $500 per family
	OUT-OF-POCKET EXPENSE MAXIMUM PER CALENDAR YEAR	None	$2,000 per individual $5,000 per family (charges applied to the deductible and those in excess of the "Allowed Amount" for any service do not apply to the out-of-pocket maximum)
	LIFETIME MAXIMUM	None	$1,000,000 per individual
	DOCTOR'S SERVICES (In Office)	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
	OFFICE VISITS	$10 copay per visit	Deductible and 20% coinsurance
	SPECIALIST VISITS	$10 copay per visit	
	CHIROPRACTIC VISITS	$10 copay per visit	
✆	SECOND OR THIRD SURGICAL OPINION	$10 copay per visit[2]	
	DIABETES EDUCATION AND MANAGEMENT	$10 copay per visit	
	ALLERGY TESTING	$10 copay per visit	
	ALLERGY TREATMENT	$0	
	DIAGNOSTIC PROCEDURES		
	• X-ray and other imaging	$0	
	• All lab tests	$0	
✆	• MRIs/MRAs	$0	
	SURGERY	$0	
	CHEMOTHERAPY	$0	
	X-RAY, RADIUM AND RADIONUCLIDE THERAPY	$0	
✆	SECOND OR THIRD OPINION FOR CANCER DIAGNOSIS	$10 copay per visit	$10 copay per visit when referred by a network physician; otherwise, deductible and 20% coinsurance

HOSPITAL AND MEDICAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

NOTE: All footnotes are explained at the end of this chart.

	YOU PAY	
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
ANNUAL PHYSICAL EXAM • One per calendar year	$10 copay per visit	Not covered

DIAGNOSTIC SCREENING TESTS
• Cholesterol: 1 every 2 years
• Diabetes (if pregnant or considering pregnancy)
• Colorectal cancer
• Fecal occult blood test, if age 40 or over: 1 per year
• Sigmoidoscopy, if age 40 or over: 1 every 2 years
• Routine Prostate Specific Antigen (PSA) in asymptomatic males
  • Between ages 40–75: 1 every 2 years
  • Over age 75: 1 per year
  • Diagnostic PSA: 1 per year
	$0	Deductible and 20% coinsurance

WELL-WOMAN CARE
• Office visits
• Pap smears
• Mammogram (based on age and medical history)
  • Ages 35–39: 1 baseline
  • Ages 40–49: 1 every 2 years
  • Age 50 and older: 1 per year
	$10 copay per visit
	$0
	$0	

WELL-CHILD CARE
• Office visits and associated lab services provided within 5 days of office visit
  • Newborn: 1 exam at birth
  • Birth to age 1: 6 visits
  • Ages 1–2: 3 visits
  • Ages 3–6: 4 visits
  • Ages 7 up to 19th birthday: 6 visits
• Immunizations
	$0
	
	$0
		Deductible and 20% coinsurance

HOSPITAL AND MEDICAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

NOTE: All footnotes are explained at the end of this chart.

		YOU PAY	
	EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
	EMERGENCY ROOM[3]	$0	$0
	PHYSICIAN'S OFFICE	$10 copay per visit	Deductible and 20% coinsurance
	AMBULANCE (local professional ground ambulance to nearest hospital)	$0 up to the Allowed Amount; you pay the difference between the Allowed Amount and the total charge	
	MATERNITY CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	PRENATAL AND POSTNATAL CARE (in doctor's office)	$0	Deductible and 20% coinsurance
	LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0	
	ROUTINE NEWBORN NURSERY CARE (in hospital)	$0	
	OBSTETRICAL CARE (in hospital)	$0	
✆	OBSTETRICAL CARE (in birthing center)	$0	Not covered
	HOSPITAL SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
	ANESTHESIA AND OXYGEN	$0	Deductible and 20% coinsurance
	BLOOD WORK	$0	
✆	CARDIAC REHABILITATION	$10 copay per outpatient visit	
	CHEMOTHERAPY AND RADIATION THERAPY	$0	
	DIAGNOSTIC X-RAY AND LAB TESTS	$0	
	DRUGS AND DRESSINGS	$0	
	GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	
	INTENSIVE CARE	$0	
	KIDNEY DIALYSIS	$0	
	PRE-SURGICAL TESTING	$0	
	SEMI-PRIVATE ROOM AND BOARD	$0	
	SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	
	SURGERY (inpatient and outpatient)[5]	$0	

HOSPITAL AND MEDICAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

NOTE: All footnotes are explained at the end of this chart.

		YOU PAY	
	DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**DURABLE MEDICAL EQUIPMENT** (i.e., hospital bed, wheelchair, sleep apnea monitor)	$0	Not covered
✆	**PROSTHETICS** (i.e., artificial arms, legs, eyes, ears)	$0	
	MEDICAL SUPPLIES (i.e., catheters, oxygen, syringes)	$0	Difference between the Allowed Amount and the total charge (deductible and coinsurance do not apply)
	NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)[6]	$0	Deductible and 20% coinsurance
	SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**SKILLED NURSING FACILITY** • Up to 60 days per calendar year	$0	Not covered
✆	**HOSPICE** • Up to 210 days per lifetime	$0	
	HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**HOME HEALTH CARE** • Up to 200 visits per calendar year (a visit equals 4 hours of care)[7]	$0	20% coinsurance only; no deductible
	• Home infusion therapy	$0	Not covered
	PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**PHYSICAL THERAPY AND REHABILITATION** • Up to 30 days of inpatient service per calendar year[7]	$0	Deductible and 20% coinsurance
	• Up to 30 visits combined in home, office or outpatient facility per calendar year	$10 copay per visit	Not covered
✆	**OCCUPATIONAL, SPEECH, VISION THERAPY** • Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$10 copay per visit	Not covered

HOSPITAL AND MEDICAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS			
		YOU PAY	
	MENTAL HEALTH CARE	IN-NETWORK	OUT-OF-NETWORK[1]
✆	**OUTPATIENT**[8] • Up to 60 visits per calendar year[7]	$25 copay per visit	Deductible and 50% coinsurance
✆	**INPATIENT** (must be rendered in an acute-care general hospital) • Up to 30 days per calendar year[7] • Up to 30 visits from mental health care professionals per calendar year[7]	 $0 $0	 Deductible and 50% coinsurance Deductible and 50% coinsurance
	ALCOHOL AND SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**OUTPATIENT** • Up to 60 visits per calendar year, including up to 20 visits for family counseling[7]	$0	Deductible and 20% coinsurance
✆	**INPATIENT** (must be rendered in a acute-care general hospital) • Up to 7 days detoxification per calendar year[7] • Up to 30 days rehabilitation per calendar year[7]	 $0 $0	 Deductible and 50% coinsurance Deductible and 50% coinsurance

[1] Keep in mind that the out-of-network deductible, coinsurance and coinsurance maximum are subject to Empire's "Allowed Amount," which is the maximum Empire pays for any service. Any portion of a charge that exceeds the Allowed Amount is your responsibility.

[2] The copayment is waived if the surgical opinion is arranged through Empire's Medical Management Program.

[3] If admitted, you or your representative must call Empire's Medical Management Program within 24 hours, or as soon as reasonably possible.

[4] Does not include inpatient or outpatient behavioral health care or physical therapy/rehabilitation. Outpatient hospital surgery and inpatient admissions need to be precertified.

[5] When two (2) or more authorized surgical procedures are performed through the same incision, Empire pays for the procedure with the highest Allowed Amount. When surgical procedures are performed through different incisions, Empire will use the Allowed Amount for the procedure with the highest allowance and up to 50% of the procedure with the lower Allowed Amount.

[6] $2,500 combined in- and out-of-network limit for modified solid food products in any continuous 12-month period.

[7] Treatment maximums are combined for in-network and out-of-network care.

[8] Out-of-network mental health outpatient visits do not require precertification.

HOSPITAL AND MEDICAL BENEFITS FOR RETIREES WHO ARE NOT MEDICARE-ELIGIBLE AND NON–MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES

NOTE: All footnotes are explained at the end of this chart.

		YOU PAY	
		IN-NETWORK	**OUT-OF-NETWORK[1]**
	DEDUCTIBLE	None	$200 per individual $500 per family
	OUT-OF-POCKET EXPENSE MAXIMUM PER CALENDAR YEAR	None	$3,000 per individual $7,500 per family (charges applied to the deductible and those in excess of the "Allowed Amount" for any service do not apply to the out-of-pocket maximum)
	LIFETIME MAXIMUM	None	$1,000,000 per individual (combined with active benefits received)
	DOCTOR'S SERVICES (In Office)	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
	OFFICE VISITS	$12 copay per visit	Deductible and 30% coinsurance
	SPECIALIST VISITS	$12 copay per visit	
	CHIROPRACTIC VISITS	$12 copay per visit	
✆	**SECOND OR THIRD SURGICAL OPINION**	$12 copay per visit[2]	
	DIABETES EDUCATION AND MANAGEMENT	$12 copay per visit	
	ALLERGY TESTING	$12 copay per visit	
	ALLERGY TREATMENT	$0	
	DIAGNOSTIC PROCEDURES		
	• X-ray and other imaging	$0	
	• All lab tests	$0	
✆	• MRIs/MRAs	$0	
	SURGERY	$0	
	CHEMOTHERAPY	$0	
	X-RAY, RADIUM AND RADIONUCLIDE THERAPY	$0	
✆	**SECOND OR THIRD OPINION FOR CANCER DIAGNOSIS**	$12 copay per visit	$12 copay per visit when referred by a network physician; deductible and 30% coinsurance otherwise

HOSPITAL AND MEDICAL BENEFITS FOR RETIREES WHO ARE NOT MEDICARE-ELIGIBLE AND NON–MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES

NOTE: All footnotes are explained at the end of this chart.

	YOU PAY	
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
ANNUAL PHYSICAL EXAM • One per calendar year	$12 copay per visit	Not covered

DIAGNOSTIC SCREENING TESTS
• Cholesterol: 1 every 2 years
• Diabetes (if pregnant or considering pregnancy)
• Colorectal cancer
• Fecal occult blood test, if age 40 or over: 1 per year
• Sigmoidoscopy, if age 40 or over: 1 every 2 years
• Routine Prostate Specific Antigen (PSA) in asymptomatic males
  • Between ages 40–75: 1 every 2 years
  • Over age 75: 1 per year
• Diagnostic PSA: 1 per year
	$0	Not covered

WELL-WOMAN CARE
• Office visits
• Pap smears
• Mammogram (based on age and medical history)
  • Ages 35–39: 1 baseline
  • Ages 40–49: 1 every 2 years
  • Age 50 and older: 1 per year
	$12 copay per visit
	$0
	$0
		Deductible and 30% coinsurance

WELL-CHILD CARE
• Office visits and associated lab services provided within 5 days of office visit
  • Newborn: 1 exam at birth
  • Birth to age 1: 6 visits
  • Ages 1–2: 3 visits
  • Ages 3–6: 4 visits
  • Ages 7 up to 19th birthday: 6 visits
• Immunizations
	$0
	
	$0
		Deductible and 30% coinsurance

HOSPITAL AND MEDICAL BENEFITS FOR RETIREES WHO ARE NOT MEDICARE-ELIGIBLE AND NON–MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES

NOTE: All footnotes are explained at the end of this chart.

		YOU PAY	
	EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
	EMERGENCY ROOM[3]	$35[3]	$35[3]
	PHYSICIAN'S OFFICE	$12 copay per visit	Deductible and 30% coinsurance
	AMBULANCE (local professional ground ambulance to nearest hospital)	$0 up to the Allowed Amount; you pay the difference between the Allowed Amount and the total charge	
	MATERNITY CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**PRENATAL AND POSTNATAL CARE** (in doctor's office)	$0	Deductible and 30% coinsurance
	LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0	
	ROUTINE NEWBORN NURSERY CARE (in hospital)	$0	
✆	**OBSTETRICAL CARE** (in hospital)	$0	
✆	**OBSTETRICAL CARE** (in birthing center)	$0	Not covered
✆	**HOSPITAL SERVICES[4]**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
	ANESTHESIA AND OXYGEN	$0	Deductible and 30% coinsurance
	BLOOD WORK	$0	
✆	**CARDIAC REHABILITATION**	$12 copay per outpatient visit	
	CHEMOTHERAPY AND RADIATION THERAPY	$0	
	DIAGNOSTIC X-RAY AND LAB TESTS	$0	
	DRUGS AND DRESSINGS	$0	
	GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	
	INTENSIVE CARE	$0	
	KIDNEY DIALYSIS	$0	
	PRE-SURGICAL TESTING	$0	
	SEMI-PRIVATE ROOM AND BOARD	$0	
	SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	
	SURGERY (inpatient and outpatient)[5]	$0	

HOSPITAL AND MEDICAL BENEFITS FOR RETIREES WHO ARE NOT MEDICARE-ELIGIBLE AND NON–MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES

NOTE: All footnotes are explained at the end of this chart.

		YOU PAY	
	DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**DURABLE MEDICAL EQUIPMENT** (i.e., hospital bed, wheelchair, sleep apnea monitor)	$0	Not covered
✆	**PROSTHETICS** (i.e., artificial arms, legs, eyes, ears)	$0	
	MEDICAL SUPPLIES (i.e., catheters, oxygen, syringes)	$0	Difference between the Allowed Amount and the total charge (deductible and coinsurance do not apply)
	NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)[6]	$0	Deductible and 30% coinsurance
	SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**SKILLED NURSING FACILITY** • Up to 60 days per calendar year	$0	Not covered
✆	**HOSPICE** • Up to 210 days per lifetime	$0	
	HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**HOME HEALTH CARE** • Up to 200 visits per calendar year (a visit equals 4 hours of care)[7]	$0	30% coinsurance only; no deductible
	• Home infusion therapy	$0	Not covered
	PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**PHYSICAL THERAPY AND REHABILITATION** • Up to 30 days of inpatient service per calendar year[7]	$0	Deductible and 30% coinsurance
	• Up to 30 visits combined in home, office or outpatient facility per calendar year	$12 copay per visit	Not covered
✆	**OCCUPATIONAL, SPEECH, VISION THERAPY** • Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$12 copay per visit	Not covered

HOSPITAL AND MEDICAL BENEFITS FOR RETIREES WHO ARE NOT MEDICARE-ELIGIBLE AND NON–MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES

		YOU PAY	
	MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**OUTPATIENT** • Up to 20 visits per calendar year	$25 copay per visit	Not covered
✆	**INPATIENT** • Up to 30 days per calendar year • Up to 30 visits from mental health care professionals per calendar year	$0 $0	Not covered Not covered
	ALCOHOL AND SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
✆	**OUTPATIENT** • Up to 60 visits per calendar year, including up to 20 visits for family counseling[7]	$0	Deductible and 30% coinsurance
✆	**INPATIENT** • Up to 7 days detoxification per calendar year	$0	Not covered

[1] Don't forget that the out-of-network deductible, coinsurance and coinsurance maximum are subject to Empire's "Allowed Amount," which is the maximum Empire pays for any service. Any portion of a charge that exceeds the Allowed Amount is your responsibility.

[2] The copayment is waived if the surgical opinion is arranged through Empire's Medical Management Program.

[3] Waived if admitted to the hospital. If admitted you or your representative must call Empire's Medical Management Program within 24 hours, or as soon as reasonably possible.

[4] Does not include inpatient or outpatient behavioral health care or physical therapy/rehabilitation. Outpatient hospital surgery and inpatient admissions need to be precertified.

[5] When two (2) or more authorized surgical procedures are performed through the same incision, Empire pays for the procedure with the highest Allowed Amount. When surgical procedures are performed through different incisions, Empire will use the Allowed Amount for the procedure with the highest allowance and up to 50% of the procedure with the lower Allowed Amount.

[6] $2,500 combined in- and out-of-network limit for modified solid food products in any continuous 12-month period.

[7] Treatment maximums are combined for in-network and out-of-network care.

OTHER MEDICAL SERVICES UNDER EMPIRE BLUECROSS BLUESHIELD

What's Covered

Covered services are listed in the charts on the preceding pages. Following are additional covered services and limitations under Empire BlueCross BlueShield:

- Consultation requested by an attending physician for advice on an illness or Injury;
- Diabetes supplies prescribed by an authorized provider:
  - ☐ Blood glucose monitors, including monitors for the legally blind;
  - ☐ Testing strips;
  - ☐ Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances and insulin infusion devices;
  - ☐ Oral agents for controlling blood sugar;
  - ☐ Other equipment and supplies required by the New York State Health Department; and
  - ☐ Data-management systems;
- Diabetes self-management education and diet information, including:
  - ☐ Education by a physician, certified nurse practitioner or member of their staff; benefits for medically necessary office visits include education at the time of diagnosis, when the patient's condition changes significantly, and when BlueCross determines medical necessity;
  - ☐ Education by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate; and
  - ☐ Home visits for education when Medically Necessary;
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition;
- Medically Necessary hearing examinations; and
- Foot care associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician.

Don't forget that this section covers only benefits provided by Empire BlueCross BlueShield. If you or a dependent has Medicare Supplemental coverage, you'll find more details in a following section. You may also contact C&R Consulting at 866-320-3807 for more information.

What's Not Covered

The following medical services are **not covered:**

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain;
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes;
- Orthotics for treatment of routine foot care;
- Routine hearing exams;
- Hearing aids and the examination for their fitting (however, these may be provided under the Fund's "Hearing Aid Benefit");
- Services such as laboratory, X-ray and imaging and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship; and
- Services given by an unlicensed provider or performed outside the scope of the provider's license.

Extra Benefits

Your Empire coverage entitles you to special benefits at fitness facilities and Weight Watchers. Check Empire's website at **www.empireblue.com** for more information.

Emergency Care

Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care the condition would:

- place your health in serious jeopardy;
- cause serious problems with your bodily functions, organs or parts;
- cause serious disfigurement; or
- in the case of behavioral health, place others or yourself in serious jeopardy.

Sometimes you need medical care for a condition that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but that is urgent and you can not wait for a regular appointment. If you need urgent care, call your physician or his or her backup. You can also call the Empire HealthLine toll-free at 877-TALK-2RN (825-5276) for advice, 24 hours a day, seven days a week.

If you make an emergency visit to your doctor's office, you pay the same copayment as for an office visit.

Please note that there may be circumstances where you will receive care in an emergency room from a non-participating provider who bills you separately from the hospital. In these instances, you may incur out-of-pocket expenses.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

If you have an emergency outside Empire's Operating Area, and you go to a BlueCross participating hospital, your claim will be treated the same as it would in Empire's network. If the hospital is not a participating hospital, then you will need to file a claim.

The following services are not covered:

- use of the emergency room to treat routine ailments, because you have no regular physician or because it is late at night (and the need for treatment is not sudden and serious); or
- ambulette.

It's important to remember that if you are admitted to the hospital in an emergency situation, you or your representative must call Empire's Medical Management Program within 24 hours, or as soon as is reasonably practical.

Maternity Care Under BlueCross BlueShield

After the initial office visit copayment, there are no out-of-pocket expenses for maternity and newborn care when you use in-network providers. In addition, routine tests related to pregnancy, obstetrical care in a hospital or birthing center, as well as routine newborn nursery care, are all 100% covered when provided in-network.

For out-of-network maternity services, you pay the deductible, coinsurance, and any amount due in excess of your plan reimbursement. Empire's reimbursement may be consolidated in up to three installments, as follows:

- two payments for prenatal care; and
- one payment for delivery and post-natal care.

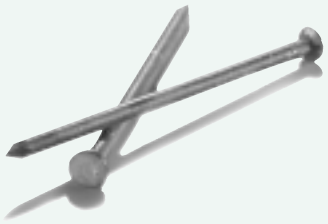
Whether you receive in-network or out-of-network services, you need to remember to call Empire's Medical Management Program at 800-841-2530 within the first three months of a pregnancy and again within 24 hours after delivery of the baby.

Covered maternity services are listed in the chart in the section called "Your PPO Benefits at a Glance." Following are additional covered services and limitations:

- One home care visit fully covered by Empire if the mother decides to leave the hospital or in-network birthing center earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this time frame (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.
- Parent education, and assistance and training in breast or bottle feeding, if available.
- Circumcision of newborn males.
- Special care for the baby if the baby stays in the hospital longer than the mother. Call Empire's Medical Management Program to precertify the hospital stay.
- A semi-private room.

These maternity services are **not covered:**

- Days in a hospital that are not Medically Necessary (beyond the 48-hour/96-hour limits).
- Services that are not Medically Necessary.
- A private room.
- Out-of-Network birthing center facilities.
- Private duty nursing.



Don't forget to notify Empire within three months after the pregnancy begins and again within 24 hours after delivery of the baby.

Newborns' and Mothers' Health Protection Act of 1996

The plan may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable). In any case, the plan may not, under federal law, require that a provider obtain authorization from Empire's Medical Management Program for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Physical Therapy and Rehabilitation

Empire BlueCross BlueShield covers up to 30 days of inpatient physical therapy and rehabilitation, and up to 30 visits combined for physical therapy in your home, doctor's office or outpatient facility. Services are covered only if they are intended to restore normal functioning that has been impaired by an illness or injury. The plan does not cover therapy to maintain or prevent deterioration of your current physical abilities. Precertification is required.

Occupational, Speech and Vision Therapy

Empire BlueCross BlueShield coverage for occupational, speech and vision therapy is provided for up to 30 visits combined in your home, doctor's office or outpatient facility. The plan does not cover tests, evaluations or diagnoses received within 12 months prior to a doctor's referral or order for occupational, speech or vision therapy.

Outpatient physical, occupational, speech and vision therapy services are available in-network only. Inpatient physical therapy can be in-network or out-of-network, but requires precertification.

Behavioral Health Care

Outpatient treatment by a licensed psychiatrist, psychologist or certified social worker with six or more years of post-degree experience will be covered by Empire for up to 60 visits per calendar year under the Active Plan and 20 visits per calendar year under the Retiree Plan. Facility charges of a hospital are covered for up to 30 inpatient days per calendar year, and the plan also covers up to 30 inpatient visits per calendar year from mental health care professionals. The plan also covers electro-convulsive therapy for treatment of mental or behavioral disorders.

All mental heath treatment, except for out-of-network outpatient services (which are available only under the Active Plan), must be precertified by Empire's Behavioral Health Care Management Program. You can reach the Program at the same toll-free telephone number that you call to precertify any other services, which is 800-553-9603. If you do not obtain precertification, coverage will be reduced by 50% for any inpatient visit or outpatient visit to an in-network provider. Coverage for inpatient hospital charges will be reduced by 50% up to a maximum of $2,500-per-inpatient admission for mental health.

The following mental health services are **not covered:**

- Care from psychiatrists, psychologists or social workers who are not certified according to New York State Insurance Law or comparable legislation outside New York State; and
- Out-of-network inpatient mental health care at a facility that is not an acute care general hospital.

The Fund complies with the Mental Health Parity Act of 1996, which prohibits annual or lifetime dollar limits on mental health benefits that are not imposed on substantially all medical and surgical benefits, effective for the first Plan year beginning on or after January 1, 1998.

Certain plan benefits — including occupational, speech, vision and physical therapy; behavorial health care; and alcohol and substance abuse treatment — have limits on the number of visits or days of inpatient care you can receive in a calendar year.

Alcohol and Substance Abuse Treatment

Empire covers outpatient services for the treatment of alcoholism and drug abuse for up to 60 visits per calendar year, including up to 20 visits for family counseling.

Inpatient treatment for alcoholism and drug abuse will be covered for up to 30 days per calendar year for rehabilitation and up to 7 days per calendar year for detoxification.

All substance abuse treatment must be precertified by Empire's Behavioral Health Care Management Program. You can reach the Program at the same toll-free telephone number that you call to precertify any other services, which is 800-553-9603. If you do not obtain precertification, coverage will be reduced by 50% for any outpatient visits. Coverage for inpatient hospital charges will be reduced by 50% up to a maximum of $2,500.

The following alcohol and substance abuse treatment services are **not covered:**

- Out-of-network out-patient alcohol or substance abuse treatment at a facility that does not meet Empire's certification requirements;
- Care that is not Medically Necessary;
- Out-of-network inpatient alcohol- or substance-abuse rehabilitation at a facility that is not an acute care general hospital; and
- Out-of-network inpatient detoxification at a facility that is not an acute care general hospital.

To receive Durable Medical Equipment and Supplies, you must go to an in-network provider.

Durable Medical Equipment and Supplies

Empire covers the full cost of Medically Necessary prosthetics and durable medical equipment from network suppliers only. Out-of-network benefits are not available.

The network supplier must precertify the rental or purchase by calling Empire's Medical Management Program at 800-553-9603. When using a supplier outside Empire's Operating Area through the BlueCard PPO Program, you are responsible for precertifying services. If you receive a bill from one of these providers, contact Member Services at 800-553-9603.

Disposable medical supplies, such as syringes, are covered up to the Allowed Amount whether you obtain them in- or out-of-network.

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available both in- and out-of network. Benefits and plan maximums are shown in "Your PPO Benefits at a Glance" section.

Covered services are listed in "Your Benefits At a Glance" section. Following are additional covered services and limitations:

- Prosthetics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
  - ☐ Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses;
  - ☐ Prescription lenses, if organic lens is lacking;
  - ☐ Supportive devices essential to the use of an artificial limb;
  - ☐ Corrective braces; and
  - ☐ Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors;
- Rental (or purchase when more economical) of Medically Necessary durable medial equipment;
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician;
- Reasonable cost of repairs and maintenance for covered medical equipment;
- Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:
  - ☐ The formula is Medically Necessary and effective; and
  - ☐ Without the formula, the patient would become malnourished, suffer from serious physical disorders or die;
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed health care provider must provide a written order.

The following equipment is not covered:

- air conditioners or purifiers;
- humidifiers or de-humidifiers;
- exercise equipment;
- swimming pools;
- false teeth (However, you may be entitled to coverage through the Fund's Dental Benefit. See the section on dental benefits for more information.); or
- hearing aids (However, you may be entitled to coverage through the Fund's Hearing Aid Benefit. See the section on Hearing Aid benefits for more information.)

HOSPITAL SERVICES UNDER EMPIRE BLUECROSS BLUESHIELD

Remember to call Empire's Medical Management Program at 800-553-9603 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or surgical procedure, call Medical Management within 24 hours, or as soon as reasonably possible. Otherwise, your benefits may be reduced by 50%.

The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not Medically Necessary, no benefits will be paid. See the "Special Programs" section for more information.

If You Visit the Hospital

Your PPO covers most or all of the cost of Medically Necessary care when you stay at a network hospital for surgery or other treatment of illness or Injury. When you use an out-of-network hospital or facility, you pay the deductible and coinsurance, plus any amount above Empire's Allowed Amount.

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

- are performed in a same-day or hospital outpatient surgical facility;
- require the use of both surgical operating and postoperative recovery rooms;
- may require either local or general anesthesia;
- do not require inpatient hospital admission because it is not appropriate or Medically Necessary; and
- would justify an inpatient hospital admission in the absence of a same-day surgery program.

Note: If you or a covered dependent is covered under the Medicare Supplemental Plan, see the next section for information on hospitalization benefits. You can also get more information on Medicare benefits by contacting Medicare at 800-MEDICARE (633-4227) or visiting its website at www.medicare.gov. You can get more information on your Medicare supplemental benefits by contacting C&R Consulting at 866-320-3807.

If surgery is performed in a network hospital, you will receive in-network benefits for the anesthesiologist, whether or not the anesthesiologist is in the network.

When you use a network hospital, you will not need to file a claim in most cases. When you use an out-of-network hospital, you may need to file a claim. See the "How to File a Claim" section for more information.

Tips for Getting Hospital Care

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

Inpatient and Outpatient Hospital Care

Covered hospital services through Empire BlueCross BlueShield are listed in the "Your PPO Benefits at a Glance" section. Following are additional covered services and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKG's, EEG's or endoscopies;
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration);
- Anesthesiologist, including one consultation before surgery and services during and after surgery;
- Blood and blood derivatives for emergency care, same-day surgery or Medically Necessary conditions, such as treatment for hemophilia; and
- MRIs/MRAs when pre-approved by Empire's Medical Management Program.

Inpatient Hospital Care

Following are additional covered services for inpatient care (coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified):

- Semi-private room and board when:
  - ☐ The patient is under the care of a physician; and
  - ☐ A hospital stay is Medically Necessary.
- Operating and recovery rooms;
- Special diet and nutritional services while in the hospital;
- Cardiac care unit;
- Services of a licensed physician or surgeon employed by the hospital;
- Care related to surgery;
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - ☐ Reconstruction following surgery;
  - ☐ Surgery on the other breast to produce a symmetrical appearance;
  - ☐ Prostheses; and
  - ☐ Treatment of physical complications at any stage of a mastectomy, including lymphedemas;
- Use of cardiographic equipment;
- Drugs, dressings and other Medically Necessary supplies;
- Social, psychological and pastoral services;
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery;
- Reconstructive surgery for a functional defect that is present from birth;
- Physical, occupational, speech and vision therapy including facilities, services, supplies and equipment; and
- Facilities, services, supplies and equipment related to Medically Necessary medical care.

Outpatient Hospital Care

Following are additional covered services for same-day care under Empire BlueCross BlueShield:

- Same-day and hospital outpatient surgical facilities;
- Surgeon;
- Surgical assistant if:
  - ☐ None is available in the hospital or facility where the surgery is performed; and
  - ☐ The surgical assistant is not a hospital employee;
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy;
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) in the following settings, until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - ☐ At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical plumbing or other fixtures needed in the house to permit home dialysis treatment are not covered); and
  - ☐ In a hospital-based or free-standing facility (see "Hospital Facility" in the "Glossary" section).

Hospice Care

Empire provides in-network coverage only for up to 210 lifetime days of hospice care to the terminally ill. Care can be provided in a hospice, the hospice area of a network hospital or at home. In order to receive maximum benefits, please call 800-553-9603 to precertify hospice care with Empire's Medical Management Program. Coverage is included for:

- up to 12 hours of intermittent care each day by a registered nurse or licensed practical nurse;
- medical care given by a hospice doctor;
- drugs and medications prescribed by the doctor (as long as they are not experimental and are approved for use by the most recent "Physician's Desk Reference");
- physical, occupational, speech and respiratory therapy for control of symptoms;
- lab tests, X-rays, chemotherapy and radiation therapy;
- social and counseling services for the patient's family, including bereavement counseling visits until one year after the patient's death;
- transportation between the patient's home and the hospital or hospice, when Medically Necessary;
- medical supplies and rental of durable medical equipment; and
- up to 14 hours of respite care in any week.

Skilled Nursing Care

Empire provides in-network coverage only for up to 60 inpatient days per calendar year in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. Prior hospitalization is not required in order to be eligible for benefits, but you must precertify. Services are covered if:

- The doctor provides:
  - ☐ a referral and written treatment plan;
  - ☐ a projected length of stay;
  - ☐ an explanation of the services the patient needs; and
  - ☐ the intended benefits of care; and

- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist or other health care professional.

The following skilled nursing care services are **not covered:**

- Skilled nursing facility care that primarily:
  - ☐ gives assistance with daily living activities;
  - ☐ is for rest or for the aged, or;
  - ☐ treats drug addiction or alcoholism; and
- Convalescent care, sanitarium-type care, or rest cures.

Home Health Care

Empire provides coverage for up to 200 precertified visits per year (combined in-network and out-of-network limit) by a state-certified home health care agency. A visit is defined as up to 4 hours of home health care, and the plan will cover up to 12 hours (three visits) of care per day. Coverage is included for part-time care by a registered nurse, licensed practical nurse, or home health aide; physical, occupational, speech and respiratory therapy (if restorative); laboratory tests; and medications, medical equipment and supplies prescribed by a doctor. The plan will also cover home infusion therapy, but only when provided by a network supplier. All home health care must be precertified by Empire's Medical Management Program. Your physician must certify home health care as Medically Necessary and approve a written treatment plan.

The plan does not cover custodial services such as bathing, feeding, or other services that do not require skilled care, nor does it cover out-of-network home infusion therapy.

Medical Necessity

Your benefits cover claims for Medically Necessary care. Services, supplies or equipment provided by a hospital or health care provider are Medically Necessary if Empire determines that they are:

- consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or Injury;
- appropriate with regard to standards of good medical practice;
- not solely for the patient's, family's or provider's convenience;
- not primarily custodial; and
- the most appropriate level of service for the patient's safety.

Only services that are "Medically Necessary" are covered by the Fund.

SPECIAL PROGRAMS PROVIDED THROUGH EMPIRE BLUECROSS BLUESHIELD

New Medical Technology

Empire uses a committee composed of Empire Medical Directors, who are doctors, and an outside medical consultant to continuously evaluate new medical technology that has not yet been designated as a covered service. If you want to request certification of a new medical technology before beginning treatment, your provider must contact Empire's Medical Management Program. The provider will be asked to do the following:

- Provide full supporting documentation about the new medical technology;
- Explain how standard medical treatment has been ineffective or would be medically inappropriate; and
- Send Empire scientific peer-reviewed literature that supports the effectiveness of this particular technology. The literature must not be in the form of an abstract or individual case study.

Empire's staff will evaluate the proposal in light of your contract and Empire's current medical policy. Empire will then review the proposal, taking into account relevant medical literature, including current peer-reviewed articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will send all decisions to the member and/or provider.

Empire's Medical Management Program

Empire's Medical Management Program is a service that precertifies hospital admissions and certain treatments and procedures to ensure that you receive high-quality care for the right length of time, in the right setting, with maximum coverage.

When you call Empire's Medical Management Program, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- learn more about your health care options;
- choose the most appropriate health care setting or services (e.g., hospital or same-day surgery unit);

- avoid unnecessary hospitalization and the associated risks, whenever possible; and
- arrange for any required (and covered) discharge services.

To help ensure that you receive quality care, Empire's Medical Management Program works with you and your provider to:

- review planned and emergency hospital admissions;
- review ongoing hospitalization;
- coordinate purchase and replacement of durable medical equipment, prosthetics and orthotics;
- review inpatient and same-day surgery;
- review routine maternity admissions;
- perform individual case management;
- review care in a hospice or skilled nursing facility;
- review home health care and home infusion therapy; and
- coordinate discharge planning.

In most cases, you or someone acting on your behalf needs to call the Medical Management Program to precertify hospital admissions and certain services. In other cases, the vendor or provider of services needs to call. This will ensure you receive maximum benefits.

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50%, up to $2,500 for each admission, treatment or procedure. This benefit reduction also applies to same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not Medically Necessary, no benefits will be paid.

Case Management

Case Management is a voluntary program that helps members with a serious chronic or catastrophic condition find quality care that is appropriate, necessary and cost efficient. A case manager works with you and your doctor to provide assistance and support, and to help arrange the treatment you need.

Case management can help with cases such as:

- cancer;
- stroke;
- AIDS;
- hemophilia; and
- spinal cord injuries.

Assistance from Case Management is evaluated and provided on a case-by-case basis. In some situations, Empire's Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the PPO is desirable, appropriate and cost effective. If you would like Case Management assistance following an illness or surgery, contact Empire's Medical Management Program at 800-553-9603.

You can reach a registered nurse 24 hours a day by calling Empire's "HealthLine" at 877-825-5276.

Empire HealthLine

Empire offers you access to a 24-hour telephone information service called Empire HealthLine. You can call Empire HealthLine anytime, 24 hours a day, to speak to a registered nurse or listen to any of over 1,100 audiotape messages on a wide variety of medical subjects. The telephone number is 877-TALK-2RN (825-5276). If you do not speak English, interpreters are also available through the AT&T language line.

Empire's specially trained nurses can answer questions and provide assistance when you need to talk to a health care professional right away. For example, you can call Empire HealthLine if your son has a fever in the middle of the night and you don't know what medicine to give him; if your daughter cuts her hand on a piece of glass and you are not sure if you need to go to the emergency room; or you sprain your ankle while travelling out of the area and do not know where to go for help.

Empire HealthLine is not for life-threatening emergencies, such as a heart attack or stroke. In these cases, call 911 or your local emergency service as soon as possible.

BlueCard Program/BlueCard Worldwide Program

Through the BlueCard Program, you can get access to Blue Cross networks throughout the United States. To receive in-network benefits, you must use a provider in the BlueCard PPO Program.

The BlueCard Worldwide Program provides hospital and professional coverage through an international network of healthcare providers, and helps you locate licensed English-speaking professionals outside the United States. Complete details on the BlueCard Program and the BlueCard Worldwide Program are available from Empire.

HOW TO FILE AN EMPIRE BLUECROSS BLUESHIELD CLAIM

If You Receive Services from a Hospital

Most hospitals in the Empire Operating Area of 28 counties in eastern New York State send bills directly to Empire. If you go to a hospital that does not participate with Empire, you may have to pay the hospital's bill. If this happens, submit a completed claim form with an Itemized Bill from the hospital to:

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

If You Receive Services from a Preferred Provider

Your provider may ask you to assign benefits, so that the provider can file a claim and be paid directly by Empire. In these instances, you will be responsible for paying the regular copayment or coinsurance to the provider. You do not have to file a claim yourself.

If You Receive Covered Services from a Non-Preferred Provider

You must complete a claim form, sign it, and send it to Empire with the original Itemized Bill(s). Be sure to keep a copy of your claim form and bills for your own records.

You may obtain a claim form by visiting Empire's website at **www.empireblue.com** or calling Member Services toll-free at 800-553-9603. Completed forms should be sent to:

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

In the section called "Claims and Appeals Procedures" you'll find additional important information on filing claims, and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Exclusions and Limitations

The following services are not covered and are not eligible for reimbursement under your Empire BlueCross and BlueShield Plan:

- Dental services, including but not limited to filling cavities, tooth extractions, periodontal treatment, orthodontia, dentures, treatment of temporomandibular joint syndrome that is dental in nature and orthognathic surgery. (Some services may be covered by the dental plan. See the section on dental benefits or contact the Fund Office for more information.)

- Services that are experimental or investigational, as determined by Empire, including any hospitalization in connection with experimental or investigational treatment. A service is generally considered to be experimental or investigational if its effectiveness has not been proven and is not generally recognized as being effective by the medical community (as reflected in published medical literature).

  Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may require that any or all of the following criteria be met to determine that a technology, treatment, procedure, biological product, medical device or drug is not experimental, investigative, obsolete or ineffective:

  ☐ There is final market approval by the U.S. Food and Drug Administration (the "FDA") for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.

  ☐ Published peer-review medical literature must conclude that the technology has a definite positive effect on health outcomes.

  ☐ Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects) or that it can be used in appropriate medical situations where the established treatment cannot be used. Published evidence must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

- Services covered under government programs, such as services provided at a veteran's hospital, or which the government has a primary obligation to pay for.

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

- Services for which there would be no charge in the absence of this coverage.

- Services performed by hospital or institutional staff that are billed separately from other hospital or institutional services, except as specified.
- Services that are not Medically Necessary in Empire's judgment, except for the preventive care previously described.
- All prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, or any other type of medication unless specifically indicated.
- Any procedure or treatment designed to alter the physical characteristics of your biological sex to those of the opposite sex.
- Any charges for a procedure to reverse sterilization, or any charges for assisted reproductive technologies including, but not limited to, in-vitro fertilization, artificial insemination, gamete and zygote intrafallopian tube transfer (GIFT and ZIFT) or intracytoplasmic sperm injection.
- Any charges for travel, even if associated with treatment and recommended by a doctor, except for ambulance transportation to the nearest hospital in an emergency.
- Services for illness or Injury received as a result of war.
- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

The following inpatient hospital services are **not covered:**

- Private duty nursing;
- A private room. If you use a private room, you must pay the difference between the cost of the private room and the hospital's average charge for a semi-private room. The additional cost cannot be applied to your deductible or coinsurance;
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life;
- Services performed in the following:
  - ☐ nursing or convalescent homes;
  - ☐ institutions primarily for rest or for the aged;
  - ☐ rehabilitation facilities (except for physical therapy);
  - ☐ spas;
  - ☐ sanitariums; and
  - ☐ infirmaries at schools, colleges or camps;

- Any part of a hospital stay that is primarily custodial;
- Elective cosmetic surgery or any related complications. However, under the Women's Health and Cancer Rights Act of 1998, health insurance plans that provide medical and surgical benefits in connection with mastectomies must also provide benefits for certain reconstructive or related services following a mastectomy. Coverage will be provided for reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of mastectomy, including lymphedemas; and
- Hospital services rendered in a clinic that does not meet Empire's definition of a hospital or other covered facility.

The following outpatient hospital services are **not covered:**

- Same-day surgery that is not precertified as Medically Necessary by Empire's Medical Management Program;
- Routine medical care including, but not limited to, inoculations or vaccinations, and drug administration or injection, excluding chemotherapy; and
- Collection or storage of your own blood, blood products, semen or bone marrow.

Converting to an Individual Policy After End of Empire Coverage

When your Fund coverage with Empire ends, you and/or your dependents may be eligible to convert to an individual plan. However, not all of your current benefits may be available when you convert your coverage. Generally, this conversion privilege is available if you or a dependent is no longer eligible for coverage under the Fund; Fund coverage ends because the Fund no longer meets Empire's underwriting standards; the Fund terminates the Empire contract and does not offer replacement coverage; or you are an Active Employee and have elected Medicare as your primary coverage.

To convert your coverage, you must be a New York State resident within Empire's Operating Area, apply for the conversion plan within 90 days of the date your Fund coverage ends and pay the premium for the conversion plan when due.

It is important to notify the Fund promptly whenever you or a covered dependent is no longer eligible for coverage. If more than 63 days elapses between your old and your new coverage, you may have to satisfy a new waiting period regarding coverage of pre-existing conditions. This rule applies not only to subsequent coverage under an Empire plan; it may also apply to coverage under another plan.

Medicare Supplemental Benefits

If you are retired and age 65 or over, or if you are under age 65 and in receipt of a Social Security Disability Award, Medicare becomes your primary source of coverage, and the Fund requires that you enroll in both Part A and Part B of Medicare. Your Welfare Fund coverage will supplement your Medicare coverage. (If you are 65 or over and an Active Employee, or if any of your qualified dependents are not eligible for Medicare, the Welfare Fund's Empire BlueCross PPO hospital and medical benefits will continue for them.)

The Medicare Program provides health insurance coverage under three distinct arrangements:

Part A – provides inpatient hospital services, post-hospital extended care services, home health services and hospice care.

Part B – provides doctors' services, outpatient hospital and a number of other health care services.

Part C – provides an alternative arrangement (Medicare+Choice).

Generally, Medicare Part A benefits require no premium payment from you. Medicare Part B, known as Supplemental Medical Insurance, is a voluntary program for eligible individuals who elect and enroll in the program and pay monthly premiums (the Part B premium may be deducted from your Social Security check). **However, the Fund requires that if you're eligible for Medicare, you must enroll in both Part A and Part B.** The Welfare Fund reimburses the Part B premium to disabled individuals under age 65 (and will reimburse the same amount if coverage is instead provided under Medicare's Plan C). If you are enrolled in Medicare Part B and eligible for Part A, you may elect Part C (Medicare+Choice), which provides an alternative to the original fee for service Medicare coverage provided by Parts A and B.

If you elect Part C coverage, you automatically waive your coverage under the Welfare Fund. If you have end-stage renal disease, you may be eligible for Medicare benefits if you require dialysis or a transplant. Call the Social Security Administration toll-free at 800-772-1213 if you have questions about your eligibility.

The Medicare benefits described in this section are subject to any limitations established by the federal government; the benefits themselves can be changed by an act of Congress. C&R Consulting, which administers the supplemental benefits, will not cover benefits for services denied by Medicare. For example, if Medicare rejects a claim as unnecessary hospitalization, C&R will not cover the claim. C&R will also reject services that Medicare never covers, such as health care received outside the U.S. (including while you're traveling), ambulette services, custodial or long-term care, and private-duty nursing. If a claim is rejected, you may appeal to the Fund Trustees. In addition, C&R will not cover charges in excess of the Medicare Allowed Amount.

Key Things to Remember about Medicare

- You must **enroll** in Medicare, **both** Part A and Part B. Coverage isn't automatic.
- Certain services aren't covered by Medicare. Some of these services include ambulette service, custodial care, private-duty nursing, acupuncture, and health care you receive outside the U.S. (even when you're traveling). If Medicare doesn't cover a particular service, then the Medicare Supplemental Plan doesn't cover it either.
- Whether you enroll or not, once you're **eligible** for Medicare, this plan will treat you as if you had enrolled. This means that if you haven't enrolled for Medicare when eligible, your plan benefit may be less than you expected.

HOSPITAL AND MEDICAL BENEFITS FOR PARTICIPANTS IN THE MEDICARE SUPPLEMENTAL PLAN FOR MEDICARE-ELIGIBLE RETIREES AND MEDICARE-ELIGIBLE DEPENDENTS OF RETIREES	
BENEFIT	**HOW IT WORKS IN GENERAL**
Hospital and Medical Benefits through C&R Consulting	For inpatient hospitalization (Medicare Part A), the plan covers the Part A inpatient deductible and the daily coinsurance you are required to pay under Medicare.
	For care in a Skilled Nursing Facility, as long as you meet Medicare's requirements, the plan will cover the daily coinsurance charge for the 21st through the 100th day of care in the Skilled Nursing Facility.
	For other medical expenses (doctor visits, etc.) covered under Medicare Part B, the plan pays the Part B deductible (currently the first $100 in Medicare-approved amounts) and then 20% of all other Medicare-approved amounts.
	Keep in Mind that no benefits are paid for charges that exceed Medicare's "approved amount" (the maximum Medicare will pay for any service).
	In general, whenever Medicare covers a particular service, C&R will pay any deductible and coinsurance required by Medicare. However, when Medicare doesn't cover a particular service, no benefits are provided through C&R. Examples of some of the services Medicare never covers include: private-duty nursing, ambulette, acupuncture, custodial care and health care received outside the U.S. (even when you're traveling).

Details About Your Medicare Benefits and Your Supplemental Benefits

Your hospital benefits under Medicare Part A pay for customary care and services provided by licensed hospitals when your physician orders hospitalization to treat an illness or injury.

Under this coverage, the following are not considered hospitals:

- Nursing or convalescent homes and institutions (Medicare benefits are, however, available for care in a skilled nursing facility, subject to the requirements discussed below);
- Institutions primarily for rest, such as spas and sanitariums; or
- Any institution primarily for treating addiction, alcoholism or mental disorders.

Inpatient Hospitalization

In most cases, such as most semiprivate hospital care, the combination of Medicare and Medicare supplemental hospital benefits will cover the full hospital bill. In other cases, you may be eligible to receive benefits for only a portion of your expenses. There may also be some expenses that do not qualify for any benefits.

Medicare Part A provides benefits, after an inpatient deductible, for the first 60 days in the hospital. Your Medicare supplemental hospital benefit covers the Medicare inpatient deductible for the first 60 days in the hospital. From the 61st to the 90th day, Medicare Part A covers most hospital charges except for a coinsurance amount per day. Your Medicare supplemental coverage pays the daily coinsurance.

If you remain hospitalized for more than 90 days, you have the option of using up to 60 lifetime reserve days under the Medicare Part A program. There is a coinsurance charge for each lifetime reserve day used, which will be paid by C&R as part of your supplemental benefits. In order for you to receive benefits, you must stay in a hospital in the U.S. or its territories, which includes all the states plus the District of Columbia, the Commonwealth of Puerto Rico, the American Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

Medicare Benefit Period

Medicare Part A coverage for necessary hospitalization is available for up to 90 days for each benefit period. Successive stays in one or more hospitals count as the same hospitalization unless 60 days or more have elapsed between the day of discharge and the next admission. If 60 days have elapsed since the last discharge, a new benefit period begins.

Skilled Nursing Facility

In addition to hospitalization benefits, Medicare Part A also covers up to 100 days of extended care (ordinary skilled nursing and rehabilitation services) in a Skilled Nursing Facility each benefit period. The facility, and your diagnosis and treatment plan, must meet Medicare's standards to be covered. Also, Skilled Nursing Facility care is covered only if it follows a hospital stay of at least three days and begins within 30 days of leaving the hospital. Medicare covers the first 20 days of care in a skilled nursing facility in full and a portion of days 21 to 100. Your Medicare supplemental coverage pays the coinsurance charges for the 21st through the 100th day.

Cost of Blood

Medicare Part A covers the cost of blood after the first three pints. Your Medicare supplemental hospital benefits cover the reasonable cost of the first thee pints of blood when administered in the hospital unless the blood is replaced or reduced by any blood deductible satisfied under Medicare Part B.

Hospital Outpatient Charges

In general, Medicare covers 80% of hospital costs for emergency room treatment, ambulatory surgery, chemotherapy, hemodialysis, diagnostic testing and other services performed in the outpatient department of a hospital. Your Medicare supplemental coverage with C&R pays the 20% coinsurance.

Medical Benefits Under Part B

Medicare Part B and your Medicare supplemental coverage help pay the cost of medical care provided by physicians, anesthesiologists, diagnostic testing centers, etc. The Medicare Part B program and Medicare supplemental coverage provide benefits when certain services are conducted in a hospital inpatient setting, the hospital's outpatient department or the physician's office.

The Medicare Part B program applies the first $100 of approved charges toward a calendar year deductible. After the deductible is satisfied, the Part B program pays 80% of approved charges. Your Medicare supplemental coverage pays the $100 deductible and 20% of Medicare's approved charge. In other words, the combination of Medicare Part B and your supplemental coverage will pay Medicare's approved charge in full. You are responsible for any charges that exceed Medicare's approved charge.

You can get more information on Medicare benefits by calling 800-MEDICARE (800-633-4227). There is also a wide range of information on Medicare benefits on the Medicare website: www.medicare.gov. For more information on the Fund's Medicare Supplemental Plan, you should call C&R Consulting at 866-320-3807.

Medical Care Outside the United States

Medicare does not cover expenses incurred outside the U.S. Since your supplemental coverage does not provide coverage for services denied by Medicare, there are no benefits for medical care provided outside of the United States.

Medical Necessity

Medicare provides benefits only for covered services that are "medically necessary." Under the Medicare law, "medically necessary" means services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care and treatment of your medical condition;
- meet the standards of good medical practice in the local area; and
- are not mainly for the convenience of you or your doctor.

How to File a Medicare Supplemental Claim

If you're covered by Medicare, your provider will generally file a claim directly with Medicare. Then, once Medicare has paid its portion, the claim will normally be forwarded to C&R Consulting. However, in the event the claim isn't automatically forwarded to C&R and you are "balance billed," you should submit the bill, along with the "Explanation of Medicare Benefits" statement you received, to:

C&R Consulting
1501 Broadway – Suite 1724
New York, NY 10036

In the section called "Claims and Appeals Procedures" you'll find additional important information on filing claims and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Special Exclusions for Medicare Supplemental Benefits

It's important that you check this section before you file for benefits. It could save you the time and trouble of submitting a claim for a service that isn't covered. When the limitations and exclusions apply to a hospital stay, no benefits will be available for any part of the hospital charges for the day or days to which they are applied.

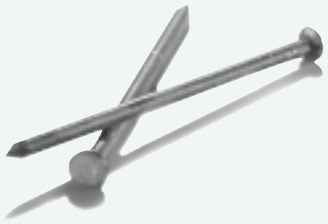
The following exclusions apply to both your Medicare Supplemental hospital and medical coverage:

- Benefits otherwise available to you under Medicare, but which you did not receive because you failed to enroll or file for those benefits;
- Services that are not needed for your proper medical care or treatment of an illness or Injury;
- Care in U.S. government hospitals or under federal, state, county, municipal or foreign government programs (except Medicare and Medicaid);
- Workers' Compensation cases or services covered under no-fault automobile insurance;
- Services usually provided without charge or for which a claim is not filed;
- Elective cosmetic surgery, except for reconstructive surgery, which is part of an operation to treat an infection, Injury or a disease, or which follows such an operation;
- Care or treatment while in prison;
- Care for surrogate mothers;
- Coverage for any weight loss or control;
- Coverage for hair loss; and
- Marriage or family counseling.

In no case will the Medicare payment plus Medicare Supplemental benefits total more than the Medicare charges allowed for the services received.

The following expenses are **not** covered by Medicare hospital benefits:

- Non-acute hospital care such as:
  - ☐ Any portion of a hospital stay that is primarily custodial;
  - ☐ A rest cure; and
  - ☐ Convalescent or sanitarium-type care;
- Non-institutional services such as private-duty nursing and practitioner services; and
- Hospital care for mental or nervous conditions, other than conditions that might be expected to improve with treatment.



For the latest information on services excluded under Medicare law, check Medicare's website at www.medicare.gov.

PRESCRIPTION DRUG PROGRAM

How the Plan Works

The plan provides coverage for prescription drugs purchased at a participating pharmacy, a non-participating pharmacy, or through a mail-order pharmacy. Coverage depends on which option you use. You will receive an ID card when your coverage starts. The following table summarizes these benefits.

Summary of In-Network Prescription Drug Benefits

Prescriptions from a participating pharmacy (up to 34-day supply)	Active Employee Plan	Retiree Plan and Medicare Supplemental Plan
Generic drugs	Plan pays 100% (no copay required)	$5 copay
"Single source" brand-name drugs (no generic equivalent)	$6 copay	$10 copay
Brand-name drugs with generic equivalents	$6 copay, plus difference between the brand-name cost and generic cost	$10 copay, plus difference between the brand-name cost and generic cost
Prescriptions from a participating pharmacy (up to 90-day supply)	**Active Employee Plan**	**Retiree Plan and Medicare Supplemental Plan**
Generic drugs	Plan pays 100% (no copay required)	$5 copay
All brand-name drugs	$6 copay	$10 copay

Using generic instead of brand-name drugs usually saves money.

Network of Participating Pharmacies

The Fund has contracted with Caremark to provide a network of participating pharmacies. These pharmacies are located nationwide and currently include K-Mart, Walgreens, CVS, Rite Aid, Revco and Genovese. Before you have a prescription filled, check to make sure the pharmacy is part of the Caremark network. You don't need to file a claim when you use a participating pharmacy. You simply show your ID card and pay the applicable copay.

If you have any questions about the Caremark network or your prescriptions, or if you need an identification card, you may call Caremark directly at 800-378-0972. Customer Service Representatives are available to help you Monday through Friday from 8:30am to 10:00pm eastern time, and on Saturday from 9:00am to 1:00pm eastern time. Claim forms are available from Caremark and the Fund Office.

Out-of-Network Pharmacies

If you go to an out-of-network pharmacy, you must pay the full cost when you pick up the prescription and then file a claim for reimbursement with Caremark. The plan will pay you the discounted amount that would have been paid to a network pharmacy. You are responsible for any difference between the Caremark network discount price and what your pharmacy charged, plus the applicable copay.

When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date, the amount, the name, the strength and the quantity of the medication. Keep a copy of your completed claim form and the receipt for your records.

Claim forms for out-of-network pharmacy benefits are available from Caremark or the Fund Office.

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Mail-Order Program

This program offers a greater discount on the cost of maintenance medication and a larger supply (90 days) per prescription. Maintenance drugs are those you must take every day for the treatment of a chronic condition, such as diabetes, asthma or high blood pressure.

Since only one copay is required for a 90-day prescription obtained through the mail-order program (as opposed to one copay for a 34-day supply from a pharmacy), you save when you use the mail-order program.

To use the mail-order program, simply mail your original prescription, your copayment (check or money order), if applicable, and a completed order form to Caremark. Your prescription will be delivered to your home via UPS or first class mail within 10–14 days after Caremark receives the order form. You will also receive a new mail-order form to be used for your next mail-order prescription or refill. Please allow sufficient time for receipt of your medication.

Forms for the mail-order program are available from both Caremark and the Fund Office.

You can receive a larger supply of medication at a lower cost when you use the mail-order program.

Expenses Not Covered

Prescription drug benefits are **not** paid for:

- Drugs and/or medications:
  - ☐ Obtained after the date coverage ends for you or your dependents;
  - ☐ Filled for more than a 34-day supply at a retail pharmacy or a 90-day supply through mail order;
  - ☐ That are experimental and/or investigational, which means they are not approved by the Food and Drug Administration (FDA) and are not legally available for distribution;
  - ☐ For which your cost is equal to or less than the copay;
  - ☐ Received while confined in a hospital (however, these costs are covered by your medical plan);
  - ☐ Dispensed for a purpose other than the treatments recommended by the FDA;
  - ☐ Prescribed as a result of an Injury or illness covered by Workers' Compensation; or
  - ☐ Intended as nutritional or diet supplements.
- Refills exceeding the number your physician prescribes;
- Refills more than one year after the date of the original prescription;
- Non-legend drugs or medications;
- Over-the-counter drugs or medications;
- Immunization agents, vaccines, biological sera, blood or blood plasma;
- Fertility medications;
- Growth hormones, except when Medically Necessary and pre-authorized;
- Alcohol wipes;
- Renova;
- Retin-A, except when Medically Necessary;
- Vitamins available without a doctor's prescription; and
- Syringes for dispensing prescribed medication (these are covered by your medical benefit).

Clinical Intervention

Caremark provides a clinical intervention process to help guard against drug interaction problems that can occur, for example, when different medications are prescribed by more than one physician or specialist. A registered pharmacist will discuss alternative medications with your doctor and notify you of any change in your prescribed medication. However, your doctor makes the final decision on all of your prescribed medications.

A clinical intervention pharmacist may also (1) suggest changing to a "formulary" drug or (2) call your doctor if the prescription instructions are different from the drug manufacturer's instructions. "Formulary drug" means a drug recommended as a generic substitution or therapeutic equivalent to, and more cost effective than, an alternative prescribed drug.

DENTAL COVERAGE

How the Plan Works

Dental benefits, which are provided by the Fund and administered by Self-Insured Dental Services Inc. (S.I.D.S.), provide you with the option of going to any dentist or selecting from a panel of "participating dentists." However, whether you go to a participating or a non-participating dentist, all benefits are paid according to a "schedule of allowances" that provides a set fee for a particular procedure.

This coverage is designed to encourage regular checkups and preventive care and to correct minor dental problems before they become serious. Benefits are provided for diagnostic and preventive services, basic restorative services, major restorative services, bridges and dentures, periodontal treatment and oral surgical procedures. Orthodontic services are also provided.

Basic and major dental services are subject to a $100 annual deductible, and all dental services are subject to a maximum Fund payment of $2,500 per person per calendar year for those participants covered by the Active Employee plan, or $1,500 per person per calendar year for those covered by the Retiree and Medicare Supplemental plans. You and your dependent Children are covered for orthodontic treatment up to a maximum Fund payment of $1,950 per lifetime.

The following chart summarizes the procedures and costs covered.

OVERVIEW OF DENTAL COVERAGE
Procedures Covered
DIAGNOSTIC AND PREVENTIVE SERVICES — routine procedures, such as oral examinations, bitewing X-rays, adult/child prophylaxis (cleaning).
BASIC SERVICES — commonly used procedures, such as amalgam fillings, simple extractions, root canals.
MAJOR SERVICES — complex extractions, periodontal treatment, extraction of impacted teeth, gum surgery, crowns, inlays, fixed bridgework, removable dentures and repairs to bridgework and dentures.
ORTHODONTIC SERVICES — correction of a handicapping malocclusion, including an initial examination, insertion of appliance and monthly treatment visits.

Network of Participating Dentists

You save money when you use dentists who are part of the S.I.D.S. network. These dentists have agreed to accept the payment provided under the Fund's schedule of allowances as payment in full (although you still have to meet any applicable deductible). For information about providers in your area, call S.I.D.S. at 516-396-5500, 718-204-7172 or toll-free at 877-592-1683, or visit their website at **www.asonet.com**.

When you use a participating dentist, subject to plan maximums and frequency limitations:

- diagnostic and preventive dental services are covered in full by the Fund in accordance with the plan's schedule of maximum allowances; and
- once you meet the deductible, basic and major restorative services are covered in full by the Fund up to the plan's maximum allowance.

If You Go to a Non-Participating Dentist

If you go to a non-participating dentist, you or your dentist will be reimbursed according to the Plan's schedule of allowances. The charges of non-participating dentists may be higher than the Plan's scheduled allowances. You are responsible for any difference between the amount your dentist charged and the amount the plan pays.

Pre-Treatment Estimate

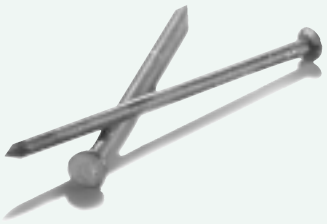
This process is intended to inform you and your dentist, in advance of treatment and before any expenses are incurred, what benefits are provided by the plan.

It is recommended that a pre-treatment estimate be filed by your dentist if your dental care is going to cost more than $300 in a 90-day period or includes any of the following services: crowns, bridges, dentures, orthodontics, inlays or periodontal surgery.

To get a pre-treatment estimate, ask your dentist to describe the treatment plan and expected cost on a claim form. X-rays are required for treatment involving root canal therapy, inlays, crowns, bridges dentures and periodontal surgery. Submit the completed form to:

Self-Insured Dental Services
P.O. Box 9007, Dept. 95
Lynbrook, NY 11563-9007

S.I.D.S. will review the proposed treatment and will send you and your dentist an explanation of benefits form that indicates the amount the plan will pay for each procedure and identifies services that are not covered or not payable by the program.



Don't forget. Whether you go to a participating or a non-participating dentist, the Plan pays up to the amount shown on the Schedule of Covered Dental Allowances.

The pre-treatment estimate will remain valid for one year, even if some or all of the work is done by another dentist. However, you must still be eligible for Fund benefits when the service is rendered, and there must have been no significant change in your dental condition since the estimate was issued. Payment will be made in accordance with plan allowances and limitations in effect at the time services are completed.

Orthodontic Services

A dentist must diagnose the need for orthodontic services and must indicate that the orthodontic condition consists of a handicapping, abnormal, correctable malocclusion. **Before treatment begins, S.I.D.S. should estimate what the plan allowance for orthodontic services will be under the pre-treatment estimate program.**

Orthodontic services are described on the following chart:

Orthodontic Service	Benefit
Diagnosis and insertion of orthodontic appliances	$450
Active treatment, up to a maximum of 24 months	$50 per month
Retention treatment following active treatment, up to a maximum of 18 months	$100 per six months

These orthodontic benefits are not subject to the annual deductible, nor do they count towards your annual maximum.

Extension of Dental Benefits

If your or your dependent's eligibility terminates in the course of certain dental treatment, and you received a pre-treatment estimate for these procedures, the patient's dental coverage will be extended for up to 90 days after eligibility would otherwise end so that the work can be completed. This limited extension applies to the following procedures only:

- Crowns, fixed bridgework and full or partial dentures — extension applies if impressions were taken and/or teeth were prepared while the patient was eligible;
- Orthodontic appliances and active treatment — extension applies if impressions were taken while the patient was eligible; or
- Root canal therapy — extension applies if the pulp chamber was opened while the patient was eligible.

There is no extension for any dental service other than those noted above.

Schedule of Covered Dental Allowances

The chart below lists all dental services covered by the plan and the maximum amount the plan will pay for each service. Remember: participating providers have agreed to accept the plan payment as payment in full, except for the $100 annual deductible.

DIAGNOSTIC & PREVENTIVE	
	PLAN PAYS
ORAL EXAMINATION maximum: two per calendar year	$15.00
FULL-MOUTH SERIES X-RAYS 10 to 14 periapical/bitewing films	30.00
PANORAMIC FILM	30.00
PERIAPICAL OR BITEWING, per film	4.00
OCCLUSAL FILM	13.00
CEPHALOMETRIC FILM	34.00
POSTERIOR-ANTERIOR FILM	29.00
LATERAL FILM	32.00
TEMPOROMANDIBULAR FILM X-ray maximum: $50 per calendar year	40.00
PROPHYLAXIS, including scaling and polishing adult child, to age 15 maximum: two per calendar year	 28.00 25.00
FLUORIDE TREATMENT excluding prophylaxis to age 15, two per calendar year	18.00
SEALANT Unrestored permanent posterior teeth only, to age 15 Lifetime maximum: $45 per quadrant	15.00
SPACE MAINTAINER acrylic metal	 98.00 135.00

BASIC RESTORATIVE	
	PLAN PAYS
SILVER AMALGAM FILLINGS	
one surface – primary	$25.00
two surfaces – primary	35.00
three or more surfaces – primary	48.00
one surface – permanent	35.00
two surfaces – permanent	45.00
three surfaces – permanent	55.00
four or more surfaces – permanent	65.00
COMPOSITE RESIN—ANTERIOR	
one surface	35.00
two surfaces	45.00
three surfaces	60.00
four or more and incisal angle	60.00
COMPOSITE RESIN—POSTERIOR	
one surface	40.00
two surfaces	50.00
three surfaces	60.00
MAJOR RESTORATIVE Preoperative periapical X-ray required. There is a five-year frequency limitation on replacements.	
CROWNS	
plastic	$120.00
porcelain jacket	325.00
plastic with metal	325.00
porcelain with metal	375.00
full cast	350.00
METALLIC INLAY	
one surface	200.00
two surfaces	250.00
three surfaces	300.00
PORCELAIN INLAY	
one surface	200.00
two surfaces	250.00
three surfaces	300.00
STAINLESS STEEL CROWN, primary tooth	100.00
CAST POST & CORE	100.00
PREFAB POST & CORE	86.00
ENDODONTICS X-ray evidence of satisfactory completion required.	
PULPOTOMY	$75.00
ROOT THERAPY	
one canal	200.00
two canals	250.00
three canals	325.00
four or more canals	375.00
APICOECTOMY	130.00
APICOECTOMY – max per tooth	260.00
RETROGRADE FILLING	60.00

PROSTHODONTICS
Preoperative X-rays are required when filing a claim for pretreatment review or payment on all prosthetics. X-rays of the full arch must be included for all bridgework. There is a five-year frequency limitation from date of installation on all prosthetics.

	PLAN PAYS
COMPLETE DENTURE immediate or permanent	 $400.00
PARTIAL DENTURE—UNILATERAL	240.00
PARTIAL DENTURE—BILATERAL acrylic base with clasps and rests cast metal base	 325.00 400.00
PRECISION ATTACHMENT	100.00
BRIDGE PONTIC full cast plastic with metal porcelain with metal	 300.00 300.00 375.00
ABUTMENT—INLAY 2 SURFACES	250.00
ABUTMENT—INLAY 3 SURFACES	300.00
CAST METAL RETNR-ACID ETCH BRIDGE	200.00
BRIDGE ABUTMENT crown – plastic with metal crown – porcelain fused to metal crown – full cast	 325.00 375.00 300.00
DENTURE RELINE—CHAIR	80.00
DENTURE RELINE—LABORATORY	125.00
DENTURE REPAIRS denture adjustment repair cast framework repair complete denture base replace tooth in denture replace broken facing add tooth to existing partial denture	 25.00 95.00 70.00 65.00 100.00 65.00
RECEMENT CROWN OR INLAY	25.00
RECEMENT BRIDGE	30.00
SURGICAL PLACEMENT OF IMPLANT	1,200.00
CUSTOM IMPLANT ABUTMENT Only payable if fabricated and placed by dentist other than provider placing the implant	200.00

PERIODONTIC SERVICES
Although eight teeth constitute the anatomic complement of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. **When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.**

	PLAN PAYS
ROOT SCALING, GINGIVAL CURETTAGE & BITE CORRECTION, INCLUDING PROPHYLAXIS, per quadrant	$50.00
two or more quadrants per visit	75.00
periodontal maintenance	60.00
maximum allowance on any combination of the above services is $200 in a calendar year	
PERIODONTAL SURGERY confirmation by charting and/or X-rays required per quadrant of at least five teeth	
localized delivery of chemotherapeutic agent maximum allowance $150 per quadrant	50.00
gingivectomy, gingivoplasty and mucogingival surgery per quadrant	150.00
osseous surgery, including gingivectomy-per quadrant	375.00
osseous graft, per quadrant	300.00
ORAL SURGERY	
ROUTINE EXTRACTION	$40.00
SURGICAL EXTRACTION must be demonstrated by X-ray	
erupted tooth	65.00
impaction – soft tissue	100.00
impaction – partial bony	175.00
impaction – complete bony	200.00
ALVEOLOPLASTY—PER JAW	125.00
BIOPSY OF ORAL TISSUE—HARD TISSUE	100.00
REMOVAL OF CYST OR TUMOR <1.25	75.00
REMOVAL OF CYST OR TUMOR >1.25	100.00
FRENULECTOMY	95.00
ORTHODONTICS	
INITIAL FIXED APPLIANCE	$450.00
ACTIVE TREATMENT—PER MONTH maximum of 24 months	50.00
POST-TREATMENT STABILIZATION DEVICE	110.00
PASSIVE TREATMENT—PER SIX MONTHS maximum of 18 months	100.00
MINOR TOOTH MOVEMENT	
removable acrylic appliance	80.00
removable metal appliance	225.00
fixed acrylic appliance	75.00
fixed metal appliance	80.00

ADJUNCTIVE SERVICES	
	PLAN PAYS
PALLIATIVE TREATMENT – no other treatment that visit	$30.00
GENERAL ANESTHESIA – plan pays first 30 minutes only	110.00
BRUXISM APPLIANCE	225.00
SPECIALIST CONSULTATION – includes examination	50.00
BEHAVIOR MANAGEMENT – only when rendered by a participating pedodontist in conjunction with other treatment only	50.00
TOOTH WHITENING – per arch must be provided by a licensed dentist using materials and equipment specifically designed to accomplish tooth whitening in a one-visit chairside setting on natural, unrestored teeth. All other tooth-whitening products or take-home methods, including those provided by a dentist, are not covered. **Lifetime Maximum** – one treatment per arch	150.00

How to File a Claim

Participating Dentist. If you receive covered services from a participating provider, you do not have to pay the dentist any money for covered services other than the deductible, if applicable, and you do not have to file a claim. The dentist's office will file the claim form. You are expected to assign benefits on the claim form so that the participating dentist can be paid directly by S.I.D.S.

Non-Participating Dentist. When you use a dentist who is not a participating provider, you or your dentist should file a claim form with S.I.D.S. Claim forms are available from S.I.D.S. or the Fund Office. When you use a non-participating dentist, you are responsible for the difference between your dentist's charges and the maximum amount listed in the "Schedule of Covered Dental Allowances." Completed forms, whether the services are provided by a participating or a non-participating dentist, should be sent to:

Self-Insured Dental Services
P. O. Box 9007
Lynbrook, NY 11563-9007

See the section called "Claims and Appeals Procedures" for additional information on filing claims and procedures to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Exclusions and Limitations

There is no coverage for:

- any charges that exceed the amounts shown in the Schedule of Covered Dental Allowances;
- treatment for the purpose of cosmetic improvement;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown, inlay or denture within five years after the date it was originally installed;
- any replacement of a bridge, crown, inlay or denture which can be made usable according to accepted dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - ☐ change vertical dimension;
  - ☐ diagnose or treat conditions or dysfunctions of the temporomandibular joint (this coverage may be covered under your medical benefits); or
  - ☐ stabilize periodontally involved teeth;
- periodontal splinting;
- multiple bridge abutments;
- a surgical implant of any type;
- over-the-counter analgesia;
- services that do not meet accepted dental standards;
- services not included in the Schedule of Covered Dental Allowances;
- services or supplies resulting from an accidental Injury, which are deemed to be the responsibility of a third party;
- any care that is covered under Workers' Compensation or a similar law, or for an Injury arising out of, or in the course of, any employment for wage or profit;
- charges made by a hospital owned or run by the United States government, unless you would be obligated to pay the charges even if you had no insurance;

- services for which payment is unlawful where the person resides when the expenses are incurred;
- services for which there would be no charge in the absence of this coverage, including services provided by a member of the patient's immediate family;
- charges for unnecessary care, treatment or surgery;
- any charges that are paid for by a government program; and
- experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Important Definitions

Dentist – A person who is licensed to practice dentistry in the state where the service is provided.

Necessary treatment – A procedure, service or supply that is required or appropriate for the treatment of your dental condition according to generally accepted standards of care.

Non-participating dentist – A dentist who does not have an agreement with S.I.D.S. to accept the Fund's maximum allowance as payment in full for covered services.

VISION BENEFITS

Vision benefits are provided through three networks of providers — Comprehensive Professional Systems (CPS), 212-675-5745, General Vision Services (GVS), 800-847-4661 and Vision Screening 800-652-0063. You may use any of these networks for your vision services, or you may use a non-network provider. Selections of frames and lenses may vary among the three networks and, in some instances, among locations in the same network.

Benefits

If you are eligible for vision benefits, you and your covered dependents are entitled to an eye examination and new glasses or contact lenses once every 12 months. If you use a participating provider, there are no out-of-pocket costs if the frames and lenses you select are part of the program. If the frames and lenses you select are outside the program, you receive a credit towards your purchase.

Covered Services

The Fund pays a participating provider $125 for an exam and a pair of frames and lenses. If you use a non-participating provider, the Fund will reimburse you up to $125 for the same package of services.

You can obtain a list of participating providers from the Fund office at 800-529-3863.

Costs

Some services that you receive from participating providers require that you pay a portion of the cost. These services and their costs are listed below. If you receive any of these services on an out-of-network basis, you will be responsible for any cost above your $125 allowance.

	Your Cost at GVS	Your Cost at CPS	Your Cost at Vision Screening
Scratch-resistant coating, single-vision	$10	$10	No charge
Scratch-resistant coating, bifocal or trifocal	$15	$15	No charge
High-index single-vision plastic lenses	$50	No charge	$50
High-index bifocal plastic lenses	$70	No charge	$50
Polycarbonate single-vision lenses	$70	$70	$30
Polycarbonate bifocal lenses	$100	$100	$75
Reflection-free coating	$40	$40	$35
Transition single-vision lenses	$75	$75	$70
Transition bifocal/ multifocal lenses	$100	$100	$90
Hyper-index	$125	$125	$125

How to File a Claim

Network provider. All you have to do is provide your name and Social Security number to the network provider. The provider will submit the claim form to the Fund Office for payment. If you receive any of the services described under "Costs" above, you will also be required to pay your share of the cost.

Non-network provider. When you use a provider who is not in the CPS, GVS or Vision Screening network, you must pay the full fee and submit a claim to the Fund Office for reimbursement. The Fund will pay only the amount it would have paid had you gone to a participating provider (up to $125 for an exam and a pair of frames and lenses).

See the section called "Claims and Appeals Procedures" for additional information on filing claims and for procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

LIFE INSURANCE

The Fund provides basic and dependent life insurance benefits at no cost to you. This coverage is provided and insured through the Union Labor Life Insurance Company ("ULLICO").

How the Plan Works

If you die while you are an Active Employee, your Beneficiary will receive a life insurance payment equal to your earnings during the highest 24 months out of the last 30 months of Covered Employment before your death. The minimum payment is $6,000 and the maximum payment is $50,000. (However, the amount of your life insurance will be reduced by any accelerated death benefit paid. The accelerated death benefit is described later.)

If you are an eligible Retiree, your coverage will continue in the amount of $8,000. There is no cost to continue life insurance coverage as a Retiree.

If you are an eligible Active Employee or Retiree, the plan also provides life insurance coverage for your dependents. If your spouse or child dies while insured under this plan, a death benefit of $1,000 will be paid to you. In order for benefits to be paid, your dependents must be eligible as defined in the plan at the time of death. When you die, coverage for your dependents ends as of that date.

Naming a Beneficiary

You must name a Beneficiary for your life insurance. Your Beneficiary may be one or more person(s), a trust, an estate, a charity, etc. In addition to naming a Beneficiary, you can also designate a contingent Beneficiary. A contingent Beneficiary receives benefits in the event the primary Beneficiary dies before you. You are automatically the Beneficiary for any life insurance coverage on your dependents.

You may change your Beneficiary at any time by submitting a new Beneficiary designation form to the Fund Office. Beneficiary designation forms are available from the Fund Office. It is important to keep your Beneficiary designation up to date.

If you do not name a Beneficiary, or if your Beneficiary dies before you, your life insurance benefit would be paid to:

- your surviving spouse or, if none,
- your Children in equal shares or, if none,
- your parents in equal shares or, if none,
- your brothers and sisters in equal shares or, if none,
- your estate.

Accelerated Death Benefit

If you're an Active Employee, you may elect to have a minimum of 25% and a maximum of 50% of your life insurance benefits paid to you while you are still living if:

- your life expectancy is six months or less; and
- you are insured for at least $10,000.

The accelerated death benefit is payable to you in a single lump sum, once in your lifetime. Upon your death, the life insurance benefit paid to your Beneficiary will be reduced by the benefits you received under the accelerated death benefit.

To apply for an accelerated death benefit, send a written request to the Fund Office. The insurance company will require a doctor's written certification that you are terminally ill with a life expectancy of six months or less (ULLICO may require an independent exam). You cannot be required to request accelerated death benefits to pay creditors, or to keep or qualify for a government benefit or entitlement or as part of a divorce settlement.

If You Become Disabled

If you are an eligible Active Employee and you become totally and permanently disabled while insured under this plan, you may qualify for a disability waiver as described in the section on eligibility and participation. If you qualify for this benefit, your life insurance will be continued for as long as you remain disabled. The amount of your life insurance coverage will be determined using the 30-month period immediately preceding the month in which you became disabled. When you reach age 65, this amount is reduced to the Retiree death benefit amount of $8,000.

You may also be entitled to pension benefits if you become disabled. Contact the Fund Office for more details.

Converting to an Individual Policy

If your life insurance with the Fund ends, you may convert all or a portion of your coverage to an individual plan. You must apply for an individual policy and pay the first month's premium within 31 days after your Fund insurance ends. If you have dependent life insurance, you may also convert the insurance on your spouse or Children to an individual policy. To apply for conversion coverage, contact ULLICO directly.

You and your dependents may not be turned down for an individual policy when you convert your life insurance within 31 days, even if you are in poor health. In addition, you will not be required to have a medical examination if you apply to convert your coverage within 31 days.

How to File a Claim

If you die, your Beneficiary or a family member should contact the Fund Office within 20 days to obtain a claim form. A Fund Office representative will provide any necessary forms within 15 days. If the forms are not provided within 15 days, you may submit any other written proof that describes the nature and extent of your claim. In addition to completing a claim form, your Beneficiary will be asked to provide proof of your death. Generally, the Fund Office will accept an original death certificate as proof of death. A life insurance claim must be filed within two years of the date of death.

In the section called "Claims and Appeals Procedures," there's additional information on filing claims and the procedures to follow in appealing a claim that is wholly or partially denied.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT (FOR ACTIVE EMPLOYEES ONLY)

How the Plan Works

The accidental death and dismemberment (AD&D) benefit is provided through a policy issued by the Union Labor Life Insurance Company ("ULLICO"). This policy pays a benefit if, as the result of an accident while you are an Active Employee, you sustain a serious Injury or die within 365 days of the accident. There is no AD&D coverage for Retirees or for your dependents.

In the event of your death due to a covered accident, AD&D benefits are payable in addition to those available under your life insurance coverage.

The maximum amount that can be paid under the AD&D plan for all losses is $6,000. This amount is also known as the "principal sum."

Schedule of Benefits

For Loss of:	The Benefit is:*
Life	$6,000
Both hands or both feet or sight of both eyes	$6,000
One hand and one foot	$6,000
Either hand or foot and sight of one eye	$6,000
Either hand or foot	$3,000
Sight of one eye	$3,000
Thumb and index finger	$1,500

* If more than one loss is suffered in the same accident, payment will be made only for the loss for which the largest amount is payable.

Your Beneficiary

Generally, the Beneficiary you name for your life insurance also is your Beneficiary for AD&D benefits. For more information, see "Naming a Beneficiary" in the life insurance section.

Exclusions

AD&D benefits cannot be paid if your loss is caused directly or indirectly, in whole or in part, by any of the following:

- medical or surgical treatment of an illness or disease;
- intentionally self-inflicted Injury, suicide or attempted suicide;

- war or an act of war, whether declared or undeclared, any act related to war or insurrection;
- injury sustained while in the armed forces or units auxiliary to the armed forces;
- injury sustained in connection with aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
- injury sustained as a pilot or crew member in any kind of aircraft, including, but not limited to, a glider, a seaplane or a hang kite;
- injury sustained or contracted as a result of intoxication or the influence of a narcotic (unless administered on the advice of a doctor);
- injury sustained while operating a motor vehicle while legally intoxicated from the use of alcohol;
- ptomaine or bacterial infections (except infections caused by pyogenic organisms that occur and through an accidental cut or wound).

How to File a Claim

Your Beneficiary or a family member should contact the Fund Office within 20 days of the event resulting in a covered loss to obtain a claim form. A Fund Office representative or ULLICO representative will provide any necessary forms within 15 days. If the forms are not provided within 15 days, you may submit any other written proof that describes the nature and extent of your claim.

With regard to accidental death claims, ULLICO requires, in addition to an original death certificate, evidence of the accidental nature of the death, such as a police report, medical report or newspaper clipping describing the accident. All claims for death benefits must be filed within two years from the date of death.

With regard to dismemberment claims, ULLICO may require that you have a medical examination that is paid for by ULLICO and conducted by a doctor chosen by ULLICO.

A completed claim form and proof of the death or dismemberment should be submitted to the Fund Office.

See the section called “Claims and Appeals Procedures” for additional information on filing claims, and procedures to be followed to appeal a claim that is wholly or partially denied.

SHORT-TERM DISABILITY BENEFITS (FOR ACTIVE EMPLOYEES ONLY)

How the Plan Works

This plan will pay you a weekly benefit if you become disabled and unable to work as the result of an Injury or illness that is not work-related. There is no short-term disability insurance for Retirees or for your dependents.

To receive disability benefits, you must be under the care of a physician and he or she must certify to the Fund that you are disabled. Weekly benefits for pregnancy will be provided in the same manner as benefits for an "illness."

When Coverage Begins

You are covered for short-term disability benefits whenever you are working in Covered Employment. You do not need to work a specified number of hours to qualify for this benefit. Therefore, you may be eligible for disability benefits even when you do not qualify for hospital and medical benefits.

When Benefits Begin

Your weekly benefit will begin on the first day of a disability resulting from an Injury or the eighth day of a disability resulting from illness. Benefits are payable as long as you remain disabled, for up to a maximum of 26 weeks of disability in any 52-week period. Under New Jersey State disability benefits law, if your disability is due to illness and lasts at least 21 days, your disability benefit is retroactive to the first day of disability.

"FICA" taxes will be withheld from any disability benefits due you.

Non–Work-Related Disability
The Plan's short-term disability benefit is generally paid only for disabilities that are not work-related. If disability is work-related, then you may be eligible for Workers' Compensation benefits.

Your Benefits

New York. Your weekly benefit is 50% of your average weekly earnings (as defined by state law) at the time you became disabled, up to a maximum benefit of $400 per week. If your disability occurs while you are actively employed or within 28 days of your last day worked, the Fund will pay you short-term disability benefits. If your disability occurs after you have been unemployed for 28 days, and you are receiving (or have filed a claim for) unemployment insurance benefits, the New York State Special Fund for Disability Benefits will pay you the short-term disability benefit.

New Jersey. Your weekly benefit is 66⅔% of your average weekly earnings at the time you became disabled, up to a maximum benefit of $450 per week. If your disability occurs while you are actively employed or within 14 days of your last day worked, the Fund will pay your short-term disability benefits. If your disability occurs after you have been unemployed for 14 days, and you are receiving (or have filed a claim for) unemployment insurance benefits, the New Jersey Special Fund for Disability Benefits will provide the short-term disability benefit.

"Average weekly earnings" means the amount, as established by state law, on which your short-term disability plan benefits are based. Generally, the eight-week period immediately preceding your disability is used to determine this amount.

How to File a Claim

Call the Fund Office toll-free at 800-529-3863 to obtain a claim form as soon as you stop working. Return the completed form to the Fund Office along with copies of your pay stubs for the eight-week period immediately prior to your disability. Be sure to keep a copy of your claim form for your own records. The Fund retains the right to ask for evidence of continued disability at any time, or to require you to see a doctor of the Fund's choosing at the Fund's expense.

See the section called "Claims and Appeals Procedures" for additional information on filing claims, and procedures to follow if your claim is wholly or partially denied and you wish to appeal the decision.

If You Are Disabled More Than Six Months

If it appears that you will be disabled for more than six months, you should contact the Fund Office. If you are disabled more than six months, you may be eligible to continue your medical and other Fund coverage under the "Disability Waiver" provision described in the section on eligibility and participation. In addition, you should contact the Fund Office to find out if you are eligible for a disability pension and, if so, how to file for it. Remember, your short-term disability benefits will end after six months.

Work-Related Disabilities

The Fund does not pay short-term disability benefits for injuries or illnesses arising out of or in the course of your employment. Your employer carries Workers' Compensation insurance for these disabilities. However, if the Workers' Compensation carrier controverts your case and issues the appropriate form (Form C-7, Notice that Right to Compensation is Controverted), the Fund can pay short-term disability benefits while your case is decided, subject to the limitations described in this section.

HEARING AID BENEFIT

You and your covered dependents are eligible for a hearing aid benefit once every four years. You may receive benefits from any hearing aid provider. However, you will receive the highest level of coverage when you use the network of participating providers affiliated with Comprehensive Professional Systems (CPS) or General Vision Services (GVS).

Covered Services

At a network location. Although you may obtain benefits at any provider, GVS and CPS have negotiated special discounts on your behalf. For a listing of providers that participate in the CPS or GVS networks, call GVS toll-free at 800-847-4661 or CPS at 212-675-5745. Coverage is provided at no cost to you at a CPS provider and for a $150 copayment at a GVS provider for the following:

- a hearing evaluation;
- a behind-the-ear, in-the-ear or otosonic hearing aid, or any comparable manufacturer's hearing aid;
- a battery for your hearing aid, with a one-year guarantee; and
- unlimited servicing of your hearing aid for one year.

If you select a hearing aid that is not part of the Fund package, you may have to make additional payments.

When you go to a non-participating provider, you will have to pay for the services you receive and submit a claim to the Fund Office. The Fund will reimburse you the same amount it would have paid if you had gone to a network provider, up to a maximum benefit of $350.

Maximum Benefit

The maximum benefit is $350 per family member for each ear, once every four years.

How to File a Claim

Network provider. All you have to do is provide your name and Social Security number to the network provider. The provider will submit the claim form to the Fund Office for payment.

Non-network provider. When you use a provider that is not in the CPS or GVS network, you must pay the full fee and submit an Itemized Bill to the Fund Office for reimbursement. Be sure to keep a copy of the bill for your own records.

See the section called "Claims and Appeals Procedures" for additional information on filing claims and procedures to follow if your claim is denied in whole or in part and you, wish to appeal the decision.

SCHOLARSHIP PROGRAM

The Fund offers a Scholarship Program for unmarried dependent Children of eligible members (including both natural or legally adopted children). For purposes of the Scholarship Program, these children are all referred to as "Qualifying Children." The Scholarship and Recognition Programs, an independent and professional organization of the Educational Testing Service of Princeton, New Jersey, administers the Scholarship Program.

Eligibility

Your Child's eligibility for this benefit depends, first, on your eligibility. You are eligible if you are working or have worked for an employer who is obligated to make contributions to the Welfare Fund for the Scholarship Program on your behalf and you meet the eligibility requirements listed below:

- you are an Active Employee; and
- you are working for or have worked for an employer who is obligated to make contributions to the Welfare Fund for the Scholarship Program on your behalf, which is referred to as "covered scholarship employment"; and
- you worked in covered scholarship employment at least 4,000 hours in the five calendar years ending on December 31 prior to the September for which the scholarship is awarded (and worked at least 600 hours in each of four of those five calendar years); or
- you worked in covered scholarship employment at least 6,000 hours in the seven calendar years ending on December 31 prior to the September for which the scholarship is awarded (and worked at least 500 hours in each of five of those seven calendar years).

If you are receiving short-term disability benefits from the New York City District Council of Carpenters Welfare Fund, Workers' Compensation or state unemployment benefits, you will receive credit for seven hours worked for each day that you receive these benefits. (Proof must be submitted.)

How the Plan Works

This benefit is a scholarship program for unmarried, dependent, natural or legally adopted Children, regardless of age, who:

- are entering college as a freshmen without prior college credit;
- are entering college with prior college credit earned while completing the senior year of high school (in an early admissions placement program or advanced placement program); or
- are mid-year graduates who entered college prior to the academic year beginning in September, when a scholarship would first be payable, and who earned one-half year of college credit.

If you are a Retiree, your Qualifying Children are eligible for this program if you met the Active Employee requirements at the time of your retirement.

If you are a Recovered Disability Pensioner, your Qualifying Children are eligible for this program provided you return to Covered Scholarship Employment for at least 1,000 hours, including at least 500 hours in the calendar year immediately preceding the September for which the scholarship is to be first awarded, and meet the requirements for an Active Employee as previously described, except that the number of calendar years in the appropriate eligibility test period may exclude those in which total and permanent disability, as recognized by the New York City District Council of Carpenters Pension Fund, existed.

Qualifying Children of deceased participants are eligible if the member had met the Active Employee requirements at the time of his death.

The Scholarship Program is not available for post-graduate work.

The Benefit

The Scholarship Program pays up to $3,500 for each year of a four-year academic program at an accredited college or university, or until the child receives a bachelor's degree, whichever occurs first.

The maximum amount of the award is $14,000 per student.

Any other financial assistance (e.g., awards, aid, loans) received by your child must be reported to the Fund Office. The Scholarship Program adjusts the scholarship so that the combination of awards does not exceed total tuition, room and board expenses and usual fees. New York State Regents awards, however, are not considered.

How to Apply

September. Call the Fund Office at 212-366-7300 in the beginning of the September of your child's senior year in high school to request an application.

November. By mid-November of your child's senior year in high school, submit the completed application to the Fund Office.

December. By December of your child's senior year in high school, your child needs to take the Scholastic Assessment Tests (SATs). **Your child needs to write "Code 0028" on the registration form for the SATs, so that the test scores will be sent to the Scholarship and Recognition Programs for their files.**

Appealing a Denied Application

If your application is denied, you may appeal the decision by filing a request for review by the Board of Trustees. Your request must be filed within 30 days after the application was denied and will be reviewed at the next quarterly Board of Trustees meeting (unless the request is received within 30 days of that meeting, in which case it will be reviewed at the second following Board of Trustees meeting).

Selection Process

An independent and professional education organization of the Educational Testing Service of Princeton, New Jersey, the Scholarship and Recognition Programs considers a number of factors in awarding scholarships: the student's high school academic record, SAT scores, moral character, leadership qualities and seriousness of purpose. The number of scholarships awarded is at the Trustees' sole discretion.

For Further Information

If you need additional information about the Scholarship Program, call the Fund Office at 212-366-7300.

COORDINATION OF BENEFITS (MEDICAL AND DENTAL BENEFITS)

You or members of your family may have other health care coverage. If this happens, the two health coverage programs will coordinate their benefit payments so that payments from the two plans combined will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Which Plan Pays Benefits First?

Here is how we determine which plan has primary responsibility for paying benefits:

- If the other plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered by one plan as an Active Employee and by another plan as a laid-off employee or Retiree, the plan that covers you as an Active Employee is primary.
- If you are covered as an employee under this plan and as a dependent under the other plan, this plan is primary.

For a dependent child covered under both parents' plans, the primary plan is:

- the plan of the parent whose birthday comes earlier in the calendar year (month and day);
- the plan that has covered the parent for a longer period of time, if the parents have the same birthday; or
- the father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility.

When the parents are divorced or separated:

- If there is no court decree establishing financial responsibility for the child's health care expenses, the plan covering the parent with custody is primary.
- If the parent with custody is remarried, his or her plan pays first, the stepparent's plan pays second and the non-custodial parent's plan pays third.

- If there is a court decree specifying which parent has financial responsibility for the child's health care expenses, that parent's plan is primary once the Fund Office knows about the decree.

If none of the previous rules apply, the plan that has covered the patient longest is primary.

If Our Plan Is the Secondary Plan

If our plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, our plan will not pay more than the amount it would normally pay if it were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.
- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

Permitted Uses and Disclosures of PHI by the Fund and the Board of Trustees

The Welfare Fund operates in accordance with the regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with respect to protected health information. A complete description of your rights under HIPAA is available in the Fund's Notice of Privacy Practices. The following statement is merely a summary of the key provisions of the Fund's Notice of Privacy Practices.

The term "protected health information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental condition or payment for health care. PHI includes all information maintained by the Fund in oral, written or electronic form (except for any information that is received in connection with the life insurance, accidental death and dismemberment benefits or disability benefits).

The Fund and the Board of Trustees are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- The Fund will disclose protected health information to the Board of Trustees only for the Trustees' use in plan administration functions, unless the Trustees have your written permission to use or disclose your protected health information for other purposes.
- The Fund has in place safeguards to protect the confidentiality, security and integrity of your health information. Protected health information that is received by the Board of Trustees from the Fund, will not be used or disclosed other than as permitted or required by this summary plan description, or as required by law, or at the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Fund.
- The Board of Trustees will not disclose your protected health information to any of its Providers, agents or subcontractors unless the Providers, agents and subcontractors agree to keep your protected health information confidential to the same extent as is required of the Board of Trustees.

- The Board of Trustees will not use or disclose your protected health information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the Board of Trustees without your specific written permission.
- The Fund may disclose protected health information to external vendors for purposes of health care management in accordance with appropriate confidentiality agreements. Data shared with external entities for measurement purposes or research will be released only in an aggregate form that does not allow direct or indirect member identification. Identifiable personal information may not be shared with the Fund Office, unless required by law.
- The Board of Trustees will report to the Fund's Privacy Officer any use or disclosure of protected health information that is inconsistent with the Fund's Privacy Policy.
- The Board of Trustees will allow you, through the Fund, to inspect and photocopy your protected health information, to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will make available to the Fund your protected health information for amendment and incorporation of any such amendments to the extent, and in the manner, required by HIPAA.
- The Board of Trustees will keep a written record of certain types of disclosures it may make of protected health information, so that the Fund can maintain an accounting of disclosures of protected health information.
- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Fund in order to allow the Secretary to determine the Fund's compliance with HIPAA.
- The Board of Trustees will return to the Fund or destroy all protected health information received from the Fund when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the protected health information, then the Trustees shall limit their further use or disclosures of any of your protected health information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

- The Board of Trustees shall ensure that adequate separation will be maintained between the Fund. Only the categories of employees enumerated hereafter and individual Trustees will be permitted to have access to and use the protected health information to perform plan administration functions. The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or on behalf of the Board of Trustees: the Fund Director, the Assistant Fund Manager and all other Welfare Fund claims staff routinely responsible for administration of claims for the Fund. Additionally, individual Trustees may receive health information from the Fund in the course of hearing appeals or handling other plan administration functions.
- If the Board of Trustees becomes aware of any noncompliance with the provisions outlined above by any of the employees listed above, the Board of Trustees will promptly report the violation to the Fund's Privacy Officer and will cooperate with the Fund to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects to the individual(s) whose privacy has been violated.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the New York City District Council of Carpenters Welfare Fund. It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. The claims procedures will vary depending on the type of your claim. The Welfare Fund has contracted with a number of health organizations ("Health Organization") to administer the different benefits components. Read each of the following sections carefully to determine which procedure is applicable to your particular request for benefits. The effective date of these procedures is July 1, 2002. These procedures supersede any prior version.

What Is a Claim

A claim is a request for benefits made in accordance with the Fund's claims procedures.

What is not a claim:

- A request for prior approval of a benefit that does not require prior approval by the plan is not a claim for benefits.
- An inquiry about plan eligibility that does not request benefits is not a claim for benefits.
- A request for verification of whether a particular service is covered under the plan is not a claim for benefits.
- The presentation of a prescription to a pharmacy to be filled under the terms of the plan is not a claim for benefits.
- A request made by someone other than the claimant or his or her authorized representative is not a claim for benefits.

Types of Claims

Precertification. Prior approval of services is required for certain medical services under the plan, including: third surgical opinions, MRIs, MRAs, cardiac rehabilitation, durable medical equipment, orthotics, prosthetics, hospice care, home health care, speech, inpatient mental health care and outpatient and inpatient alcohol or substance abuse treatment. Please refer to each specific section of this Plan for more information on precertification. If you fail to precertify these services, no Plan benefits will be payable for the services.

Urgent. An Urgent Care Claim is when the plan requires precertification of a benefit with respect to medical care or treatment where applying non-urgent time frames:

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

Whether your claim is an Urgent Care Claim is determined by the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

Concurrent. If the plan has approved an ongoing course of treatment covering either a period of time or a number of treatments, any reduction or termination before the end of the approved treatment is a concurrent care decision. For example, if an inpatient hospital stay was initially certified for five days and, upon further review, determined to be certified for only three days, the decision to reduce the length of treatment was made concurrently with the provision of treatment.

Retrospective. A retrospective request is any claim submitted for payment after the service or treatment has been rendered to you.

Disability. A disability claim is any claim that requires a finding of total disability as a condition of eligibility for a benefit. The Fund reserves the right to have a Physician examine you (at the Fund's expense) as often as is reasonable while a claim for disability benefits is pending.

AD&D. An Accidental Death and Dismemberment (AD&D) claim is any claim for loss of life, limb(s) or sight of eye(s) caused directly and independently by an accident. For benefits to be payable, the loss must occur within 365 days of such accident, the loss must be listed in the schedule of benefits and it must be directly the result of the injuries and independent of all other causes.

Life insurance. A life insurance claim is any claim for payment made by your beneficiary on the occasion of your death.

How to File a Claim

A claim form may be obtained from the Fund Office by calling 800-529-3863 or from the specific Health Organization listed below. The claim form should be completed in its entirety and submitted to the appropriate Health Organization. If a request is filed improperly or the form is incomplete, the request will not constitute claim under these procedures.

You will only receive notice of an improperly filed claim if the claim includes (i) your name, (ii) your specific medical condition or symptom and (iii) a specific treatment, service or product for which approval is requested. Check the claim form to be certain that all applicable portions of the form are completed. Include with the claim form any itemized bills if services have already been provided to you or any documentation requested to verify your claim. If the claim forms have to be returned to you for information, delays in processing the claim will result.

A claim form that is incorrectly sent to the Fund Office will be redirected to the appropriate Health Organization. The applicable time frame for processing the claim will begin to run from the date the claim is received at the appropriate Health Organization (discussed further below in "When Claims Must Be Filed").

Authorized Representatives

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

When Claims Must Be Filed

Claims should be filed in writing as soon as possible after the date the charges are incurred. Your claim will be considered to have been filed as soon as it is received by the appropriate Health Organization that is responsible for making the initial determination of the claim. Urgent claims, however, may not be submitted in writing, but must be submitted by telephone to the appropriate Health Organization.

Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred. Claims for life insurance benefits must be filed within two years of the loss.

Where to Submit Your Claims

The contact information for each Health Organization for you to use to submit initial claims is as follows:

Hospital and Medical Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attn: Institutional Claims Department
Telephone: 800-553-9603

Prescription Drug Claims:

Caremark
P.O. Box 686005
San Antonio, TX 78268-6005
Telephone: 800-378-0972

Dental Claims:

Self-Insured Dental Services (S.I.D.S.)
P.O. Box 9007, Department 95
Lynbrook, NY 11563-9007
Telephone: 877-592-1683

In-Network Vision Claims:

If you go to a network provider, submit your name and Social Security number to the provider. The provider will submit the claim form to the Fund Office for payment.

In-Network Hearing Claims:
If you go to a network provider, submit your name and Social Security number to the provider. The provider will submit the claim form to the Fund Office for payment.

Out-of-Network Vision Claims and Out-of-Network Hearing Claims:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
Telephone: 800-529-3863

Short-Term Disability Claims:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
Telephone: 800-529-3863

Accidental Death and Dismemberment (AD&D) and Life Insurance Claims:

New York City District Council of Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
Telephone: 800-529-3863

The Fund will review the claim for eligibility and completeness and then forward the claim to ULLICO at:

111 Massachusetts Ave., N.W.
Mail Stop 709
Washington, DC 20001
Telephone: 866-795-0680

Claims Review Process

After you submit a properly completed claim form, the Health Organization will review the claim and make a decision within the applicable time frames for decisionmaking.

Time Frames for Decisionmaking

The applicable Health Organization will comply with the following time frames in processing your claim, which vary depending on the type of claim submitted:

- **Precertification** – The Health Organization will review all requests for precertification within 15 days of receipt of the request. If the Health Organization does not have enough information to make a decision within 15 days, it will notify you in writing as soon as possible but not later than 5 days after receipt of the claim of the additional information needed, and you and your provider will have 45 days to respond. The Health Organization will make a decision within **15 days** of receipt of the requested information, or if no response is received, within 15 days after the deadline for a response.

- **Urgent Precertification** – The Health Organization will review all requests for urgent precertifications within **72 hours** of receipt of the request. If further information is needed to make the decision, the Health Organization will notify you by telephone within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. Notice of the decision will be provided within 48 hours of receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.

- **Concurrent** – A claim to continue or extend treatment should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. The applicable Health Organization will complete all concurrent reviews of services as soon as possible but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

- **Retrospective** – The applicable Health Organization will complete all retrospective reviews of services already provided within **30 days** of receipt of the claim. If the Health Organization does not have enough information to make a decision within 30 days, it will notify you in writing before the end of the initial 30-day period of the additional information needed, and you and your provider will have 45 days to respond. The Health Organization will make a decision within 15 days of receipt of the requested information, or if no response is received, within 15 days after the deadline for a response. If an extension is necessary due to matters beyond the Health Organization's control, it will notify you in writing before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision, but the extension may be no more than 15 days.

- **Disability** – The Fund will complete its review of a disability claim within **45 days** of receipt of the claim. If an extension is necessary due to matters beyond the Fund's control, it will notify you in writing before the end of the initial 45-day period of the date by which it expects to render a decision. The Fund will make a decision within 30 days of the time it notifies you of the delay, or an additional 30 days if it notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days to respond. During the period in which you are allowed to supply additional information, the Fund's 45-day period for making a decision will be suspended until either 45 days or the date you respond to the request (whichever is earlier). The Fund will make a decision within 30 days of receipt of the requested information, or if no response is received, your claim will be denied.
- **AD&D** – same as retrospective requests.
- **Life Insurance** – same as retrospective requests.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). A denial of a claim may also include any claim where the plan pays less than the total amount of expenses submitted regarding a claim. This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim or a statement that it is available upon request at no charge.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

Internal Review Process

If your claim is denied in whole or in part, or if you disagree with the initial decision made on a claim, you may ask for a review by filing an appeal with the Health Organization. An appeal is a request to have the Health Organization reconsider a denial based on a finding that the service is not medically necessary or is considered to be experimental or investigational. A grievance is a request to have the Health Organization reconsider a denial based on any other terms of the plan.

How to File a Request for Review

Your request for review must be made in writing to the Health Organization within **180 days** after you receive notice of denial. If the appeal or grievance is not submitted within that time frame, the Health Organization will not review it and its initial decision will stand. The contact information for each Health Organization is provided below:

Hospital and Medical Appeals:

Appeals:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attn: Institutional Claims Department
Telephone: 800-553-9603

Grievances:

Empire BlueCross BlueShield
Medical Management Appeals Department
Mail Drop 60
P.O. Box 11825
Albany, NY 12211
Telephone: 800-553-9603

Dental Appeals:

Self-Insured Dental Service (S.I.D.S.)
P.O. Box 9007, Dept. 95
Lynbrook, NY 11563-9007
Telephone: 516-396-5500, 718-204-7172
or 877-592-1683

Vision, Hearing or Prescription Drug Benefit Appeals:

The Board of Trustees
New York City District Council of
Carpenters Welfare Fund
395 Hudson Street
New York, NY 10014
Telephone: 800-529-3863

AD&D and Life Insurance Appeals:

ULLICO
111 Massachusetts Ave., N.W.
Mail Stop 709
Washington, DC 20001
Telephone: 866-795-0680

Short-Term Disability Appeals:

In NY State:
Workers' Compensation Board
Disability Benefits Bureau
100 Broadway–Menands
Albany, NY 12241

In New Jersey:
Division of Temporary Disability Insurance
Private Plan Operations
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625

Your Rights in the Review Process

- You have the right to review, free of charge, documents, records or other information relevant to your claim. A document, record or other information is relevant if it was relied upon by the plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the plan's administrative processes for ensuring consistent decisionmaking; or it constitutes a statement of plan policy regarding the denied treatment or service.
- The appeal will be reviewed by an appropriate named fiduciary who is not the individual who initially denied your claim (or the first appeal decision in cases with more than one level of appeal).
- The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional written documents, records and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.
- The health care professional shall be an individual who is neither the individual who was consulted in connection with your original appeal or the subordinate of such individual.
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Time Frames for Appeals Decisionmaking

After you submit a request for review to the appropriate Health Organization, it will comply with the following time frames in processing your request for review, which vary depending on the type of initial claim submitted: For medical, hospital and dental retrospective requests, there are two levels of appeals and grievances with the applicable Health Organizations, plus a voluntary third level of appeal. For all other retrospective requests, there is one level of appeal described below.

Empire BlueCross BlueShield or S.I.D.S.

First Level. The Health Organization will comply with the following time frames in reviewing First Level appeals and grievances:

- Precertification — The Health Organization will complete its review of a precertification appeal within **15 days** of receipt of the appeal.
- Urgent — If the need for the service is urgent, the Health Organization will complete the review as soon as possible, taking into account the medical circumstances, but in any event within **72 hours** of our receipt of the appeal. The determination will also be confirmed in writing no later than three days after the oral notification.
- Concurrent — The Health Organization will complete its review of a concurrent appeal within 15 days of receipt of the appeal; provided however, that if the need for the service is urgent, it will complete the review as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the appeal.
- Retrospective — The Health Organization will complete its review of a retrospective appeal within **30 days** of receipt of the appeal.

Second Level. Your request must be received within 60 days of the date of the decision on your First Level appeal or grievance. If the appeal or grievance is not submitted within that time frame, the Health Organization will not review it and the decision on the First Level appeal or grievance will stand. The Health Organization will comply with the following time frames in reviewing Second Level appeals and grievances:

- Precertification — The Health Organization will complete its review of a precertification appeal within **15 days** of receipt of the appeal
- Urgent — There is no second level of appeal for urgent precertification requests.
- Concurrent — The Health Organization will complete its review of a concurrent appeal within 15 days of receipt of the appeal; provided however, that there is no second level of appeal for urgent concurrent requests.
- Retrospective — The Health Organization will complete its review of a retrospective appeal within **30 days** of receipt of the appeal.

Third Level. The third level of appeal is a voluntary procedure.

Should an adverse determination be made upon review of your claim by S.I.D.S. or Empire BlueCross BlueShield, you will have an opportunity to choose a voluntary third level of appeal before the Board of Trustees. To request this third level voluntary appeal, or if you have any questions, please call the Fund Office. This third level of appeal is not required by the plan and is only available if you or your authorized representative request it.

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

Appeals heard by the Board of Trustees. Decisions on appeals involving vision, hearing and prescription drug benefits will be made by the Board of Trustees at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached. The decision by the Board of Trustees shall be final and binding on all parties.

Disability claims: Decisions on appeals involving disability claims will be reached within 45 days of your request for a review. However, in special circumstances, up to an additional 45 days may be necessary to reach a final decision on a disability claim. You will be advised in writing within the 45 days after receipt of your request for review if an additional period of time will be necessary to reach a final decision on your disability claim.

Accidental Death and Dismemberment (AD&D) and Life Insurance Claims. ULLICO will make a decision within **60 days** following receipt of your request for a review.

Notice of Decision on Review

The decision on any review of your claim (both before and after the voluntary third level of appeal) will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination.
- Reference to the specific plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement describing the plan's voluntary appeal procedures and your right to obtain information about such procedures.
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim, or a statement that it is available upon request at no charge.
- **The following statement:** "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. However, a lawsuit may be started prior to you requesting or submitting a benefit dispute to any voluntary third level of appeal. The law also permits you to pursue your remedies under section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them.

GLOSSARY

Active Employee	An individual who works for an employer that has an agreement with the Union that requires contributions to this plan and who has met the Fund's eligibility requirements for active plan participation.
Allowed Amount	The Allowed Amount is the maximum charge the plan recognizes for any service and on which plan payments are based.
Beneficiary	The individual(s), trust or estate that you name to receive benefits under the Life Insurance and Accidental Death and Dismemberment insurance coverage, if you should die.
Children	Your eligible dependent Children include your biological child, adopted child (including a child who has been placed with you for adoption) or stepchild, as long as the child is unmarried and primarily dependent upon you for support and maintenance.
Covered Employment	is when you are working for an employer that is required by a collective bargaining agreement or participation agreement to contribute to the New York City District Council of Carpenters Welfare Fund on your behalf.
Disabled Child or Children	A Disabled Child is an unmarried child of any age who is incapable of self-sustaining employment due to physical or mental handicap. The handicap must begin before age 19 or 25, when coverage for the child would usually end. Written evidence of the handicap must be sent to the Fund Office within 60 days of the date when coverage would usually end and when requested by the Fund thereafter.
Hospital Facility	A fully licensed acute-care general facility that has all of the following on its own premises: ■ a broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies; ■ 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times; ■ a fully staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care; ■ assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies; ■ diagnostic radiology facilities; ■ a pathology laboratory; and ■ an organized medical staff of licensed doctors.

	For pregnancy and childbirth services, the definition of a "hospital" includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan. For physical therapy purposes, the definition of a "hospital" may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan. For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate. For behavioral health care purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral health care services. For alcohol and/or substance abuse treatment received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). For certain specified benefits, the definition of a "hospital" or "facility" may include a hospital, hospital department or facility that has a special agreement with Empire. Empire's PPO does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities; institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.
Injury	A bodily Injury resulting directly from an accident and independently of other causes, which occurs while you are covered under this plan.
Itemized Bill	An Itemized Bill is a bill from a provider, hospital or ambulance service that gives information that the health care organization needs to consider your claim. Provider and hospital bills will contain the patient's name, diagnosis and date and charge for each service performed. A provider bill will also have the provider's name and address and description of each service, while a hospital bill will have the employee's name and address, identification number and the patient's date of birth. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled and charges.

Medically Necessary	Services, supplies or equipment provided by a hospital or other provider of health services are Medically Necessary if they meet the definitions of medical necessity in the sections on Empire and Medicare benefits.
Operating Area	The Empire Operating Area includes the following 28 counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester. The counties include the five boroughs of New York City, Long Island and certain areas in upstate New York.
Retiree	An individual who is "Totally Disabled" or who is receiving retirement benefits under the New York City District Council Carpenters Pension Fund and meets the plan's eligibility requirements for retiree coverage.
Totally Disabled	During the first 24 months after you stop working due to a disability, you will be considered Totally Disabled if you are unable to perform work in Covered Employment. After 24 months, you will be Totally Disabled if your disability prevents you from performing work in any occupation. If you are eligible for Social Security disability benefits, you will automatically be considered Totally Disabled. In all cases, you must be an eligible Active Employee when you become disabled.

OTHER THINGS YOU SHOULD KNOW

Plan Amendments or Termination

The Board of Trustees intends to continue the Welfare Fund indefinitely; however, it reserves the exclusive right to amend, modify, suspend, increase the cost of or terminate the plan at any time, in accordance with the procedures specified in the Trust agreement. Upon termination of the plan, the Trustees shall apply the monies of the Fund to provide benefits or to otherwise carry out the purposes of the plan in an equitable manner, until the entire remainder of the Fund has been disbursed.

Representations

No local union officer, business agent, local union employee, employer or employer representative, Fund Office personnel, consultant or individual trustee or attorney is authorized to speak for the Trustees or commit the Trustees on any matter relating to the Plan, without the express written authority of the Trustees.

The Board of Trustees is the named fiduciary that has the discretionary authority to control and manage the administration and operation of the plan and Trust. The Board shall have the full, exclusive and discretionary authority to make rules, regulations, interpretations and computations, construe the terms of the plan, and determine all issues relating to coverage and eligibility for benefits. The Board may also take other actions to administer the plan as it may deem appropriate. The Board's decisions, interpretations and computations and other actions shall be final and binding on all persons.

Plan Interpretation

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

No Liability for the Practice of Medicine

Neither the Fund nor the Trustees or any of their designees are engaged in the practice of medicine or dentistry; nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered by any health care provider; nor shall any of them have any liability whatsoever for any loss or Injury caused by any health care provider because of negligence, because of failure to provide care or treatment, or otherwise.

Subrogation and Reimbursement

When benefits are paid or payable to or for a participant or dependent ("covered person") under the terms of this plan, the plan shall be subrogated to the rights of recovery of such a covered person against any person or entity who is liable for the injury that necessitated the hospitalization or the medical or surgical treatment for which the benefits were paid. Such subrogation rights shall also extend to any recovery by such a covered person of any proceeds paid under any liability or casualty insurance policy or program, or under any insurance or self-insurance program other than this plan. Such subrogation rights shall extend only to the recovery by the plan of the benefits it has paid for such hospitalization or treatment. The covered person is obligated to avoid doing anything that would prejudice this plan's rights of subrogation and reimbursement. If the covered person to whom benefits are paid or payable under this plan fails to bring suit promptly against a third party, the plan may, in its discretion, commence any legal action or administrative proceeding it deems necessary to protect its right to recovery and try or settle that action or proceeding in the name of and with the full cooperation of the covered person, but, in doing so, the plan will not represent or provide legal representation for the covered person with respect to his or her damages that exceed the benefits paid by the plan.

In the event the plan should request information from the claimant regarding material necessary for the implementation of this subrogation provision with respect to a claim, the plan reserves the right to withhold payment of such claim pending the submission of the requested information.

If the covered person does not reimburse the plan as required by this provision, the plan may, in its sole discretion, apply any future benefits that may become payable on behalf of the covered person to the amount not reimbursed, or obtain a judgment against the covered person from a court for the amount not reimbursed and garnish or attach the wages or earnings of the covered person.

PLAN FACTS

Official Plan Name	New York City District Council of Carpenters Welfare Fund
Employer Identification Number (EIN)	13-5615576
Plan Number	501
Plan Year	July 1– June 30
Type of Plan	Welfare benefit plan providing medical, hospital, dental, vision, hearing, disability, prescription drug and life insurance benefits.
Funding of Benefits	All contributions to the Welfare Fund are made by employers in accordance with collective bargaining agreements and participation agreements in force with the District Council or the Fund. These agreements require contributions to the Welfare Fund at fixed rates. A copy of any such agreement may be requested or examined at the Fund Office.
Trust	Contributions to the Welfare Fund are held in a trust under The Agreement and Declaration of Trust Establishing the New York City District Council of Carpenters Welfare Fund, as the same may be amended from time to time. The custodian for the Trust is The Bank of New York.
Plan Administrator	The New York City District Council of Carpenters Welfare Fund is administered by a joint Board of Trustees composed of twelve trustees: six designated by employer organizations and independent employers and six designated by the District Council. Their names appear later in this brochure. The office of the Board of Trustees may be contacted at: Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300
Plan Sponsor	The New York City District Council of Carpenters Welfare Fund is sponsored by the joint Board of Trustees. The office of the Board of Trustees may be contacted at: Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300

Trustees	Board of Trustees New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 212-366-7300
Participating Employers	The Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Welfare Fund on behalf of employees, as well as the address of such employer. Additionally, a complete list of employers and unions participating in the Welfare Fund may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.
Agent for Service of Legal Process	Executive Director, New York City District Council of Carpenters Welfare Fund 395 Hudson Street New York, NY 10014 Legal process may also be served on the Plan Administrator, the individual Trustees, any insurer of benefits, or, with regard to any such insurer, the supervisory official of the local state insurance department.

Other Administrative and Funding Information

This section provides important information about third parties involved in providing and administering Plan benefits. You may want to refer to this section for information if a question arises concerning a particular benefit.

Medical benefits. Benefits for active participants and retirees who are not Medicare-eligible are self-funded; that is, they are paid out of Fund assets. The Fund has contracted with Empire BlueCross and BlueShield to administer the program on its behalf. In addition to forwarding to Empire amounts required to pay Plan benefits, the Fund also pays Empire an administrative fee. Empire then assumes the responsibility for providing the benefits called for under its contract. Empire may be contacted at:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Telephone: 800-553-9603
www.empireblue.com

Benefits for individuals in the Medicare Supplemental Plan are also self-funded and are administered by C&R Consulting. C&R can be reached at:

C&R Consulting
1501 Broadway – Suite 1724
New York, NY 10036
Telephone: 866-320-3807

Prescription drug benefits. Benefits under this program are paid out of Fund assets. The Fund has contracted with Caremark to administer the program on its behalf. In addition to forwarding to Caremark amounts required to pay plan benefits, the Fund also pays Caremark an administrative fee. Caremark can be reached at:

Caremark
2211 Sander Road
Northbrook, IL 60062
Telephone: 800-378-0972
www.caremark.com

Dental benefits. Benefits under this plan are paid out of Fund assets. The Fund has contracted with S.I.D.S. to provide claims and other administrative services. The Fund pays S.I.D.S. a fee for these administrative services, in addition to forwarding to it the amounts required to pay plan benefits.

S.I.D.S. can be contacted at the following address:

Self-Insured Dental Services
P.O. Box 9007, Dept. 95
Lynbrook, NY 11563-9007
Telephone: 516-396-5500, 718-204-7172
or toll-free 800-537-1238
www.asonet.com

Vision benefits and hearing aid benefit. Benefits under this plan are paid out of Fund assets. The Fund has contracted with General Vision Services ("GVS"), Comprehensive Professional Systems ("CPS") and Vision Screening to provide access to participating providers, process claims and other administrative services. (Vision Screening provides only vision services.) The Fund pays GVS, CPS and Vision Screening a negotiated fee. GVS can be reached at the following address:

General Vision Services
330 West 42nd Street
New York, NY 10036
Telephone: 212-594-2580

CPS can be reached at the following address:

Comprehensive Professional Systems, Inc.
48 West 21st Street
New York, NY 10010
Telephone: 212-675-5745

Vision Screening can be reached at the following address:

Vision Screening
1919 Middle Country Road
Centereach, NY 11720
Telephone: 631-467-4515

Life insurance and accidental death & dismemberment insurance. Benefits under these plans are insured by Union Labor Life Insurance Company ("ULLICO"). The Fund pays premiums to ULLICO for the coverage and ULLICO assumes responsibility for the payment of benefits. ULLICO can be contacted at:

ULLICO
111 Massachusetts Ave., N.W.
Mail Stop 709
Washington, DC 20001
Telephone: 866-795-0680

Short-term disability benefits. Benefits under this plan are paid out of Fund assets and administered through the Fund Office.

Scholarship program. Scholarship benefits are paid out of Fund assets and administered through the Fund Office.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the New York City District Council of Carpenters Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the plan, including summary plan descriptions, collective bargaining agreements and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health 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.
- Receive a certificate of creditable coverage, free of charge, from your group health plan 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 new group health plan.

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest Office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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