NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

NYC District Council of Carpenters Welfare Fund

summary plan description

for active employees of participating employers and associations

4502.11
NYCDCC Welfare-Participating SPD
Layout #1 8/7/03
Marjorie Gross & Company

TABLE OF CONTENTS

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ABOUT THIS BOOKLET

This handbook summarizes the benefits available to you under the New York City District Council of Carpenters 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 administrador del plan al 800-529-3863 para ayuda.

AN OVERVIEW OF YOUR WELFARE BENEFITS

Your employer has arranged to make certain health care benefits available to you under The New York City District Council of Carpenters Welfare Fund (the "Fund").

These benefits include:

- medical benefits (hospitals, doctors and other necessary medical services), as well as prescription drug benefits, and
- dental coverage (if your employer has also elected to provide it).

This handbook offers a comprehensive resource you can use when you or your family members need information about 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	Empire BlueCross BlueShield 800-553-9603
Prescription drug coverage	Caremark 800-378-0972 800-831-4440
Dental coverage	Self-Insured Dental Services 877-592-1683 516-396-5500 718-204-7172
Plan Administration and all other questions	The Fund Office 212-366-7300 800-529-3863

Participants may also seek assistance or information from the Department of Labor regarding their rights under ERISA and HIPAA.

ABOUT YOUR PARTICIPATION

Eligibility for Active Employees

You are eligible to participate in this Plan on the first day of the calendar month following one full calendar month of "Full-Time Active Employment."

> **Example:** Assume you begin work on February 15, 2003 as a Full-Time Active Employee. You are eligible to participate in the Plan on April 1, 2003.

"Full-Time Active Employment" means you are regularly scheduled to work at least 35 hours per week for a "Participating Employer," pursuant to the applicable participation agreement.

"Participating Employer" means an employer that is a member of the Building Contractors Association, the Manufacturing Woodworkers Association of Greater New York, the Floor Coverers Association, the Association of Wall-Ceiling Carpentry Industries, or the Cement League and that has elected to participate in the Welfare Fund pursuant to a participation agreement.

When we use the term "Covered Employment" in this booklet, we mean periods of employment when contributions are made to the Fund on your behalf.

Dependent Coverage

If you are covered, your eligible dependents may also be covered if your employer pays for family coverage. 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; and
- unmarried Disabled Children of any age who are primarily dependent upon you for support.

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, prescription drug and dental coverage that you do.

Words that are capitalized in this summary—such as "Active Employee," 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.

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; 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, provided you enroll them for coverage.

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 to a child under a group health plan. 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 212-366-7300 or toll-free 800-529-3863** if you have either a change of address or a change in family status, including:

- marriage, divorce or annulment;
- birth, adoption of a child or placement of a child with you for adoption;
- 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 take a leave of absence, including military leave and leave for family or medical purposes;
- a covered dependent dies; or

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

- 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 212-366-7300 or 800-529-3863.

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

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 coverage, as described later. In such a case, 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.

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 and 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 die;
- You or your covered dependents no longer meet the Fund's eligibility requirements;
- You retire;
- The Fund, insurance company or your employer 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' insurance will end on the date your insurance 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 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 continuation 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 continuation coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you 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 continuation 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 Continuation 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 COBRA 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.

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 continuation 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 are no longer eligible 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, you or your dependents will *not* be entitled to COBRA continuation coverage. After the Fund has been notified of a qualifying event, the Fund Office 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 continuation coverage, your coverage will end.

Paying for COBRA continuation 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.

When COBRA continuation coverage ends. Your continued coverage under COBRA may end for *any* of the following reasons:

- You have continued coverage for the maximum 18-, 29- or 36-month period.
- The Fund no longer provides group health coverage.
- The Fund terminates your coverage for cause, such as fraudulent claim submission, on the same basis that coverage could terminate for a similarly situated Active Employee.
- You do not pay the cost of your COBRA continuation coverage when it is due or within any grace period.
- You become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply to you.
- 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.

Once your COBRA continuation 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.

COBRA claims. Claims incurred by you will not be paid unless you have elected COBRA continuation 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 PROVIDED THROUGH BLUECROSS BLUESHIELD

How the Plan Works

The Fund's hospital and medical coverage is offered through a "PPO" (preferred provider organization) administered by Empire BlueCross BlueShield ("Empire"). Your coverage includes a wide range of medical services:

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

The section called "Your PPO Benefits at a Glance" has more details on which services need to be precertified.

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."

In-Network and Out-of-Network Services

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 services. However, some services are only available in-network; 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.

> **Example.** 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 pays 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.

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.

✆ 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]	$0	Deductible and 50% coinsurance
• Up to 30 visits from mental health care professionals per calendar year[7]	$0	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]	$0	Deductible and 50% coinsurance
• Up to 30 days rehabilitation per calendar year[7]	$0	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 48 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.

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:

- 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.

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;
- 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.

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 48 hours, or as soon as is reasonably practical.

Sometimes you need medical care for a condition that is not an emergency (e.g., bronchitis, high fever, sprained ankle), but is urgent and you cannot 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.

Maternity Care

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, insurance 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 postnatal care.

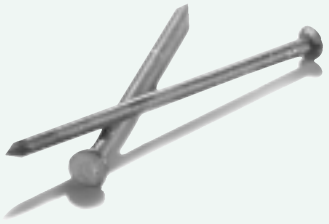
Whether you receive in-network or out-of-network services, you need to remember to call Empire's Medical Management Program at 800-553-9603 within the first three months of a pregnancy and again within 24 hours after delivery of the baby.

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

The plan provides coverage for 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.

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.

Occupational, Speech and Vision Therapy

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 for up to 60 visits per calendar year. 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 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.

Alcohol and Substance Abuse Treatment

Outpatient services for the treatment of alcoholism and drug abuse will be covered 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.

Durable Medical Equipment and Supplies

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

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 the "Your PPO Benefits at a Glance" section.

Covered services are listed in the "Your PPO 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, and 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; and
- 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.

HOSPITAL SERVICES

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.

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 "Hospital and Medical Claims" section for more information.

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.

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 services 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 EKGs, EEGs or endoscopies;
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration);
- Anesthesiologist, including one consultation before surgery and services during and after surgery;
- Blood and blood derivatives for emergency care, same-day surgery, or Medically Necessary conditions, such as treatment for hemophilia; 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:

- 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; and

- 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 freestanding facility (see "Hospital Facility" in the "Glossary" section).

Hospice Care

The plan 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 that 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

The plan 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

The plan 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

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.

Empire HealthLine

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

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 if you sprain your ankle while traveling 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 health care 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.

HOSPITAL AND MEDICAL CLAIMS

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 and over-the-counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, or any other type of medication, unless specifically indicated in the Empire BlueCross documents.
- 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

When your Fund coverage with Empire ends, you and/or your dependents may be eligible to convert to an individual plan with comparable benefits. 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 elapse 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.

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)	Benefit
Generic drugs	Plan pays 100% (no copay required)
"Single source" brand-name drugs (no generic equivalent)	You have a $6 copay and plan pays the balance
Brand-name drugs with generic equivalents	You pay $6 copay, plus difference between the brand-name cost and generic cost, and plan pays balance
Prescriptions through the mail-order program (up to 90-day supply)	**Benefit**
Generic drugs	Plan pays 100% (no copay required)
All brand-name drugs	You have a $6 copay and plan pays balance

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.

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

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.

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

You have dental benefits only if your employer has elected to provide them. Contact the Fund Office to verify your eligibility for dental benefits.

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. 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.

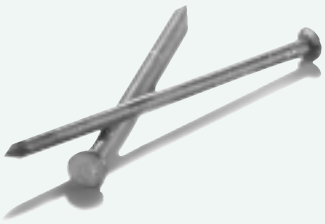
OVERVIEW OF DENTAL COVERAGE
Procedures Covered
DIAGNOSTIC AND PREVENTIVE SERVICES — routine procedures, such as oral examinations, bitewing X-rays, and adult/child prophylaxis (cleaning).
BASIC SERVICES — commonly used procedures, such as amalgam fillings, simple extractions, and root canals.
MAJOR SERVICES — 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 treatments.

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 payment 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:

- 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.



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 allowances.

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

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, orthodontics, inlays, dentures or periodontal surgery.

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.

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 crowns, bridges, dentures, inlays and periodontal surgery. Submit the completed form to:

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

S.I.D.S. reviews the treatment plan and sends both you and your dentist an explanation of benefits form that indicates the amount the plan will pay for each procedure and identifies services not covered by the program.

The pre-treatment approval 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 the condition of your mouth since the estimate was issued.

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, months up to a maximum of 18 months	$100 per six

These orthodontic benefits are not subject to the annual deductible, nor do they count toward the 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 approval 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	325.00
cast metal base	400.00
PRECISION ATTACHMENT	100.00
BRIDGE PONTIC	
full cast	300.00
plastic with metal	300.00
porcelain with metal	375.00
ABUTMENT—INLAY 2 SURFACE	250.00
ABUTMENT—INLAY 3 SURFACE	300.00
CAST METAL RETNR-ACID ETCH BRIDGE	200.00
BRIDGE ABUTMENT	
crown – plastic with metal	325.00
crown – porcelain fused to metal	375.00
crown – full cast	300.00
DENTURE RELINE—CHAIR	80.00
DENTURE RELINE—LABORATORY	125.00
DENTURE REPAIRS	
denture adjustment	25.00
repair cast framework	95.00
repair complete denture base	70.00
replace tooth in denture	65.00
replace broken facing	100.00
add tooth to existing partial denture	65.00
RECEMENT CROWN OR INLAY	25.00
RECEMENT BRIDGE	30.00
SURGICAL REPLACEMENT OF IMPLANT	1,200.00
CUSTOM IMPLANT ABUTMENT	
Only payable if fabricated and placed by dentist other than providing 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	50.00
maximum allowance $150 per quadrant	
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	50.00
maximum of 24 months	
POST-TREATMENT STABILIZATION DEVICE	110.00
PASSIVE TREATMENT—PER SIX MONTHS	100.00
maximum of 18 months	
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, Inc.
P. O. Box 9007, Dept. 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; or
  - ☐ diagnose or treat conditions or dysfunctions of the temporomandibular joint (this coverage may be covered under your medical benefits);
- 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, and that 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.

COORDINATION OF BENEFITS (MEDICAL, PRESCRIPTION DRUG)

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 to 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 (such as a QMCSO) 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 This Plan Is the Secondary Plan

If this 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, this 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.

CONFIDENTIALITY

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.

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 later. 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.

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

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.

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

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

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 timeframes 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 decision-maker and any circumstances that may affect the impartiality of the decision-maker.
- 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 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.

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 employee who is currently and continuously engaged in Full-Time Active Employment.
Allowed Amount	The Allowed Amount is the maximum charge the plan recognizes for any service and on which all plan payments are based.
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 participation agreement to contribute to the Fund on your behalf.
Disabled 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 definition of medical necessity in the applicable section of this booklet. The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it Medically Necessary.
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.

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.

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 and prescription drug benefits.
Funding of Benefits	All contributions to the Welfare Fund are made by employers in accordance with collective bargaining or participation agreements in force with the District Council or the Fund. These agreements require contributions to the Welfare Fund at specified 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	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. Medical benefits 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

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

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

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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INSIDE
BACK
COVER